REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

THE EFFECTS OF DEINSTITUTIONALIZATION

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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To: The Governor and the General Assembly of Virginia
From: Anne G. Rhodes, Member of the House of Delegates
Subject: Report of the Joint Subcommittee to Study the Effects of Deinstitutionalization

The Commonwealth of Virginia, like many other states, has long been striving to find a workable system which will provide additional appropriate services in a cost-effective and efficacious manner to those persons with mental health, mental retardation and substance abuse problems. With the advent of additional therapies and the drive to treat consumers in the community, with the institutional facilities being only a part of a continuum of services, many community programs have been initiated to meet those needs. Unfortunately, community treatment and the new managed care technologies are struggling to meet the needs of today's consumers in a fiscal system which does not easily allow the funds saved at institutions to be reinvested in the client.

This Joint Subcommittee has made certain recommendations to address this issue, but they are preliminary. While recognizing that additional study and evaluation was needed, the Joint Subcommittee agreed that these recommendations could provide an impetus for long-needed reforms in the funding of mental health, mental retardation and substance abuse services in the Commonwealth. For this reason, the Joint Subcommittee suggested that continued legislative oversight was needed for this vitally important project and that this report be sent to the 1996 HJR 240 legislative study on the Future Delivery of Publicly-Funded Mental Health, Mental Retardation and Substance Abuse Services. An outline of this report was also transmitted to the House Appropriations and Senate Finance Committees during the 1996 Session of the General Assembly.

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I. EXECUTIVE SUMMARY

Deinstitutionalization, in the original concept of moving individuals out of institutions and providing them with community supports to achieve their treatment goals, is no longer a goal, but an actuality. Many Virginians with mental health needs are currently receiving services in the community which has enabled them to avoid institutionalization, thus bypassing the heretofore traditional usage of the term "deinstitutionalization." While institutions rightfully must be a vital part of the continuum of services needed by some clients, it is but one part of that continuum.

The Commonwealth, like many other states over the past thirty years, has endeavored to find ways to provide the community supports necessary to met the crucial needs of the client requiring services from the mental health, mental retardation and substance abuse system, but has encountered numerous impediments to a design which recognizes a true continuum of services where the funding stream meets the needs of the individual rather than the system structure. The concept of "single stream funding" has long been the goal of the system but implementation has been hindered because of a system which does not allow substantial reinvestment of institutional savings to meet the need of the client in the community. The joint subcommittee, after hearing much testimony and examining the needs of the system which provides services to the mentally disabled, concluded that the time has come to look to the future and develop a system which can more fully help current clients as well as those on waiting lists.

During this time period, since the inception of the community-based treatment and the establishment of the community services boards system, several legislative commissions, including the Bagley and Hirst Commissions, as well as studies by the Joint Legislative Audit and Review Commission, have endorsed the importance of care in the least restrictive environment possible. In that time, the average daily population census of mentally ill clients treated in state mental health facilities has dropped from 9,343 in 1970 to 2,417 in 1995, and the census in the state mental retardation facilities has likewise dropped from 5,327 to 2,249 in that same period. But recent figures show that while facilities serve only 4.8 percent of the mentally disabled population, funding for those facilities accounted for 68.1 percent of state support for the mental health budget and 49.7 percent of the system's total federal, state, local, and fee support. On the other hand, approximately 95.2 percent of the mentally disabled population were served

through the community services boards, using 26.6 percent of the state budget and 46.7 percent of the system's total federal, state, local, and fee support. Unfortunately, while specific projects have been able to transfer funds for the purposes of census reduction, state budgeting and statutory restrictions prohibit the general transfer of any resultant savings at institutions to the community services sector. Funds realized through budget economies usually return to the General Fund. Today, although the state serves over 185,000 citizens each year, another 10,000 remain on waiting lists. As a caveat, though, differentials must be noted when comparing a number of services, both in their intensity and resultant cost. Services provided in facilities are clearly more intensive and therefore are more expensive than community services in general, so there is not a direct one-to-one correlation. However, the Joint Subcommittee, while recognizing these differentials, felt that it would behoove the state to carefully examine other funding methodologies which might have the potential capacity to more nearly serve the clients' needs in a fiscally responsible and efficacious manner. Clearly, a change is in order and is supported by all of the various players, including the Department of Mental Health, Mental Retardation and Substance Abuse Services, the CSBs, and consumers and families.

The joint subcommittee made significant headway in putting these issues on the table and identifying a number of concepts which, if implemented properly, it felt would enhance the mental health service delivery system and truly provide adequate and appropriate services to the client. These concepts, in brief, include:

- The Department of Mental Health, Mental Retardation and Substance Abuse Services is the state MHMRSAS authority, responsible for the overall planning and development of a continuum of mental health, mental retardation and substance abuse services to individuals with serious mental illnesses, mental retardation and substance abuse problems throughout the Commonwealth. As the state MHMRSAS authority, the Department is responsible for assuring accountability to the Governor and General Assembly through such mechanisms as licensing providers, negotiating performance contracts with CSBs, establishing guidelines for services, monitoring outcomes, and assuring consumer access, participation and rights. However, it is imperative that community-based planning, including consumers, families, local government, providers and others who have a stake in the provision of care, continue to be a vital, driving force in the determination and provision of such care.
- The Commonwealth, in developing a system that not only contains cost but also is outcome oriented to provide for better, more appropriate care, must place the needs and desires of the client in primary focus.
- Funding for services for the mentally disabled in the Commonwealth does not yet meet the needs of the client population and, therefore, should not be decreased at this time. Inherent in this concept is the determination or definition of eligible populations.

- Savings realized from the downsizing of mental health facilities should be redirected to the benefit of the client population rather than the general fund as currently mandated by the Department of Planning and Budget.
- In this day of increased pressures brought on by continued downsizing of state facilities without reinvestment of funds saved into the system, anticipated changes in federal programs of Medicaid and mental health and substance abuse block grant funding, and greater use of managed care, every effort must be taken to maximize and protect the funds which are available through a number of methods, including waivers for "carve-outs" for Medicaid funds which are used for the delivery of mental health and mental retardation services or to ensure that the same funds are available under a state block grant scheme.
- In order to accomplish single stream funding, consideration must be given to the idea of redirecting facility funding to be integrated with all other mental health, mental retardation and substance abuse funding currently available to serve Virginians in need of such services so that, indeed, the stream of funding follows the client.
- To deliver adequate services which are appropriate to the client, a network of public and private providers must continue to be utilized and expanded.
- To be fiscally responsible, the system should contain costs and not be shifted to local governments.
- In order to test the concept of redistribution of funds from institutions to community-based care, the joint subcommittee supports the creation of one or more pilot projects, to be implemented by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Plans for such projects should be presented prior to implementation and should include requirements for regular oversight and evaluation.

The joint subcommittee, during its first year of deliberations, did offer legislation to enhance the process of outpatient commitment. Serving the client in the community is the hallmark of the community-based system of services, but determination of appropriate clients who can be properly treated in the community is difficult. Judges, for the most part, must decide, based on testimony from the client, advocates, and mental health professionals whether the client is capable of benefiting from such treatment and these judges have stated that the guidelines were too vague, and guarantees of services to be provided were not always available. To address this, the joint subcommittee recommended legislation which would provide additional guidelines for the judge as well as guarantees of service provisions and a "contract" with the client in which the client indicates a desire for outpatient treatment and agrees to participate in his treatment. House Bill 2126, passed by the 1994 Session of the General Assembly, added language to the Code regarding involuntary commitment and treatment (§ 37.1-67.3) which provides that after the judge initially determines that the client needs treatment and that less restrictive alternatives to institutionalization are suitable, and if the judge subsequently determines that . . ."(i) the patient has the degree of competency necessary to understand the stipulations of his treatment, (ii) the patient expresses an interest in living in the

community and agrees to abide by his treatment plan, (iii) the patient is deemed to have the capacity to comply with the treatment plan, (iv) the ordered treatment can be delivered on an outpatient basis, and (v) the ordered treatment can be monitored by the community services board or designated providers, then the judge shall order outpatient treatment..."

II. AUTHORITY FOR STUDY

In 1994, the General Assembly of Virginia passed House Joint Resolution No. 139 which authorized a joint subcommittee of members of both the House of Delegates and the Senate as well as a number of citizen representatives to examine the effects of the state policy of deinstitutionalization of person with mental disabilities. The study was continued into 1995 by House Joint Resolution No. 549.

III. BACKGROUND

A. History

"Deinstitutionalization" in the Commonwealth was a policy decision made in the early 1970s to systematically implement large scale reductions in bed capacities at large state facilities. This was accomplished when appropriately-diagnosed consumers with mental health, mental retardation and substance abuse treatment needs were, and continue to be, referred through cooperative planning with CSBs to programs in the community. Community placement is felt to be the least disruptive and the most cost-efficient in both human and medical terms. Since so many clients are currently being treated in the community, the term "deinstitutionalization" is passé and a misnomer in terms of the delivery of mental health services today. Because of this, "community-based services" will be used for the purposes of this report to describe the delivery of community-based mental health services.

Beginning with the campaign by Dorothea Dix to humanize the treatment of the mentally ill by introducing "moral treatment," consisting of occupational, recreational, and educational therapies, into treatment thought and procedures, the process of successfully treating individuals with mental illness, mental retardation and substance abuse problems in the home and community began. Unfortunately, early institutions were unable to provide adequate services at a cost-effective rate and the treatment of individuals with mental illness, mental retardation and substance abuse problems was still stigmatized. Historians have documented the increasing acceptance of community treatment, beginning about the time of World War II, for a variety of reasons, including

(i) public acceptance of the treatability of mental illness was greatly enhanced with experiments during the war with front-line treatment and return to service; (ii) psychotropic drugs made their debut and improved treatment of a variety of mental disabilities; (iii) the civil rights movement began the campaign for adequate and least restrictive treatment; and (iv) the cost of institutional care began to rise sharply, making community care a more viable and attractive alternative in order to care for more consumers.

Community-based treatment, nationally as well as in the Commonwealth, began in the 1960s and 1970s. Inspired by complaints about the "warehousing" of individuals with mental illness, mental retardation and substance abuse problems as well as complaints about the institutional system and the inherent costs, the process of community-based treatment was enabled by the development of new forms of mental health treatment as well as new types of drug therapies. Since 1970, the average daily population census of consumers housed in institutions in Virginia has dropped from 9,343 to 2,417 in 1995. The census in state mental retardation facilities has likewise dropped from 5,327 to 2,249 in that same period.

Community-based treatment efforts in the Commonwealth began in the 1940s with the establishment of mental hygiene clinics which were operated by the Department but which also had local advisory boards and included local matching funds. Virginia's community-based treatment efforts as we know it today began in 1968 with the passage by the General Assembly of Chapter 10 of Title 37.1 of the Code of Virginia, which initiated local establishment and control of mental health and mental retardation services by community services boards. Many of the original local mental hygiene boards were incorporated in the new CSB system. This enabling legislation provided the means for the implementation of the recommendations of the Hirst Commission, which found that ". . .the successful improvement of mental health services to both the mentally ill and the less fortunate of Virginia's citizenry requires a total commitment to the concept of a coordinated system of care focused on the patient rather than the agency or institution." Continued lack of adequate community services led, in 1977, to the creation of the Bagley Commission which observed that " . . .unfortunately, the impetus to remove individuals from institutional care has superseded the development of viable alternatives for the appropriate care of the mentally handicapped at the community level." Additional studies have made similar observations and recommendations for strengthening the community-based system, but, while numbers of institutionalized patients and lengths of hospital stay have decreased, the services provided in the community have not been able to meet the needs of all consumers. For those consumers with homes and families it has been documented that aftercare is relatively inexpensive; for those without, community care with all its inherent components, can be more expensive than institutional care. But, the end result can be a functioning citizen whose quality of life is inherently better and who gives back to the community and state.[1]

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[1] C. Knight Aldrich, "Deinstitutionalization", *Newsletter*, University of Virginia Institute of Government, Vol. 62, No. 1, September 1985.

The Joint Subcommittee Studying the Effects of Deinstitutionalization undertook a review of the process of providing community-based care not in terms of the policy itself but in the ramifications such a policy has had on individuals with mental illness, mental retardation and substance abuse problems and the community. Certain primary issues were presented over the two-year study, including (i) developing a policy as to which consumers the state will be able to treat; (ii) determining what services are needed; (iii) estimating the cost of these services; (iv) applying the savings realized in the downsizing of institutions to community-based services; (v) establishing a funding stream which will follow the consumer; and (vi) determining which fiscal and management techniques best meet the needs of the consumer, both current and prospective, and the state. "Single-stream funding" which works to allow the funding for services to follow the consumer to wherever services are available or are needed was felt to be the major issue under consideration. Other states have wrestled with this phenomenon and some have embarked upon ambitious programs to "reinvest funds" realized by the downsizing of institutions, but the joint subcommittee feels that a more moderate, gradual approach is necessary to ensure that current individuals in need of mental health, mental retardation and substance abuse services as well as those on waiting lists are provided uninterrupted services and that the transition in program funding be an orderly, responsible, and accountable process. In addition, it is necessary to maintain necessary institutional services for consumers in need of such services in the total continuum of services.

Testimony during the course of this study addressed some of the positive aspects of the provision of community-based treatment. The impact on consumers of services and their families has been positive, including:

- With support, an independent and productive life with employment potential and community participation is now possible.
- Family connections, including a network of support for day-to-day problem-solving, are now maintained.
- Early intervention in the mental illness is now possible, perhaps avoiding the need for hospitalization completely, including access to immediate emergency response.
- Dependence on public services has been reduced through the encouragement of regular, active treatment.
- A reduction of community bias or stigma results when a person with a mental illness is a neighbor, a customer or an employee, reducing isolation and feelings of helplessness among consumers and their families.

The impact of community-based services on communities has likewise been positive:

- Increased sensitivity to and support for diversity and differences.

- Employment and training programs have resulted in an increased pool of trained and committed workers available to support economic development.
- Closer working relationships developed between public agencies, such as public safety, social services, housing, mental health, and other agencies, often including cross-training activities which have benefited all citizens.
- The development of services and technologies which have been available to all citizens.
- Decreased public cost associated with earlier intervention versus inpatient care.

Likewise, as with any system of services, some problems have been experienced in the delivery of community-based mental health, mental retardation and substance abuse services, including:

- Often there is a higher concentration of persons with serious mental illness in cities due to greater availability of low-cost housing, public transportation, adult care residences and other public services. A similar concentration has occurred in localities in which large facilities are located.
- Conversely, in other areas, persons with serious mental illnesses are isolated from comprehensive services, including health care.
- The concentration of public services and affordable housing in some communities has often forced people to relocate to those areas and, as a result, separate from family and community support. For example, the adult care residence industry in many communities in Virginia has resulted in enormous service demands, further stressing the local community system.
- While the site of the delivery of mental health, mental retardation and substance abuse services has largely been shifted from state facilities to community programs, the funds have not followed and, as a result, services in most communities are not as comprehensive as needed. State budgetary procedures and statute prohibit the easy transfer of funds realized from savings at facilities to community services, requiring, instead, that such funds revert to the General Fund. However, several special projects have accomplished such transfers. For instance, the Eastern State Census Reduction Project, implemented several years ago, was partially financed with funds from Eastern State Hospital's operating budget ($500,000 out of the $1.8 million total). And more than $3.7 million was transferred from state facilities to finance community services as part of the Department's census reduction plan several years ago. Another mechanism which may hold potential for continued shifts of resources, on a consumer-specific basis, is the Medicaid Mental Retardation Home and Community-Based Waiver. In the last year, $6.2 million has been transferred from large facility budgets to be used as match for waiver-funded community placements and other administratively-handled transfers, which are possible without legislative

action. Unfortunately, this is still a fragmented and cumbersome transfer process which, hopefully, can be streamlined to benefit all consumers of mental health, mental retardation and substance abuse treatment services.

- The few individuals for whom community discharges were inadequately coordinated and planned are often perceived as representing the large population of persons with serious mental illness who have been, and are, successfully served. When a discharge from a state facility is unsuccessful it is usually a result of (i) inadequate availability of services in the home community, (ii) lack of coordinated discharge planning between the facility and the community, or (iii) a decision by the consumer, upon discharge, to relocate or not to participate in treatment (the person may not meet the legal definition for involuntary commitment involving being unable to care for himself or presenting a danger to himself or others).

B. Constitutional Issues

At this time, least restrictive care is not only an admirable goal, but it is required by law. State statute, especially in regard to the involuntary commitment provisions, requires that a person not only need treatment but also that he present a danger to himself or others, is not capable of caring for himself, and should receive care in the least restrictive environment. A majority of the Supreme Court found in *Zinermon v. Burch* (110 S.Ct.987) that " . . .the involuntary placement process serves to guard against the confinement of a person who, though mentally ill, is harmless and can live safely outside an institution. Confinement of such a person . . .is unconstitutional." *Shelton v. Tucker* (364 U.S.479) addressed the issue of least restrictive environment by stating that " . . even legitimate governmental purposes may not be pursed in ways that intrude on fundamental personal liberties when the same purposes can be achieved using less intrusive means."[2]

C. Current Trends

In Virginia, certain trends in the utilization of mental health and mental retardation facilities must be noted:

- Although the average daily census significantly decreased and admissions declined in recent years, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) projects an increase of 2.7 percent in total admissions to all facilities by the year 2000 and a decrease of 12.6 percent in the average daily census.

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[2] John Parry, "Involuntary Civil Commitment in the 90s: A Constitutional Perspective, *Mental and Physical Disability Law Reporter*, Vol. 18, No. 3, pp 320-336.

- In 1993, the average length of stay in state mental health facilities was half of what it was in 1975. The median stay was 23 days in 1994.
- The DMHMRSAS projects a decrease of 32.5 percent in the total number of training beds from FY 96 to FY 2010.

D. Inventory of Services Coordinated by CSBs

To gain insight into the range and variety of services coordinated for mentally disabled clients by the CSBs in the state, the joint subcommittee requested an inventory to be compiled. Although offering a variety of services, not all CSBs provide all the services in any one locality.

During fiscal year 1993, this system provided:

- case management to 57,947 persons at an average cost of $635 per person.
- emergency interventions to 56,118 persons at an average cost of $300 per person with six hours of service per episode.
- outpatient therapy to 103,866 persons including 13,077 children, averaging $711 per person with ten hours of therapy per episode.
- residential support to 11,210 persons through a wide range of housing options.
- substance abuse treatment to more than 13,000 persons involved in the criminal justice system.
- community-based services to 19,952 persons who had been served in state psychiatric hospitals.

(For a complete breakdown of service usage and costs, please see Appendix B.)

Regional and local community services boards operate as providers in an integrated human services system statewide with:

Public schools to:

- Provide counseling and treatment to more than 13,000 children, youth and families each year.
- Provide infant and toddler intervention to 4,285 children per year and transition them to the public schools.
- Provide extensive substance abuse prevention activities in the public schools.
- Jointly develop and implement treatment plans for at-risk youth through the Comprehensive Services Act.

Courts and Law Enforcement to:

- Process all civil commitment actions through the courts in Virginia.
- Provide forensic evidence to the courts (mental status exams, competency to stand trial, and expert evidence).
- Provide crisis intervention/suicide assessment in jails.
- Provide substance abuse treatment to jail inmates.
- Monitor Not Guilty by Reason of Insanity (NGRI) clients in the community for the court system.
- Provide substance abuse treatment to persons on probation and parole.
- Provide training on mental illness and crisis management for local law enforcement officers.
- Implement "duty to warn" processes when clients threaten to harm others.
- Provide outpatient treatment to the Department of Youth and Family Services clients.

Community Hospitals to:

- Locate available inpatient bed capacity in local or area hospitals in response to crisis situations.
- Facilitate admissions for individuals in need of inpatient psychiatric services.
- Process civil commitment cases for local hospital psychiatric units.
- Coordinate transfer of persons from community hospitals to state psychiatric facilities when required.
- Provide comprehensive community support (treatment and psychosocial rehabilitation) services for patients discharged from inpatient care when appropriate.
- Assist emergency room staff in dealing with psychiatric and substance abuse emergencies.

State Psychiatric Hospitals to:

- Prescreen all admissions to state psychiatric hospitals and arrange admission when required.
- Manage admissions by diverting persons with health insurance to other regional and community inpatient resources.
- Arrange housing for discharged clients when required.
- Provide case management and other community services for consumers discharged from the state psychiatric hospitals.

Additionally, CSBs maintain other major linkages with:

- Departments of Social Services in foster care and family preservation.
- Area Agencies on Aging in various cooperative agreements and consultation.
- Private non-profit human services agencies in joint case planning consultation and purchase of services.
- Business and industry for Employee Assistance Programs (EAP), education and prevention, and managed care contracts.

Community Services Boards see as their system strength their ability to:

- Provide statewide coverage.
- Coordinate with other key human services systems.
- Maintain a close link with local government.
- Create a diversity and wide array of services to meet local needs and priorities.
- Develop a close linkage with a variety of disability advocacy groups.
- Operate regional and sub-regional service components.
- Maintain a wide range of 501(c)(3) corporations to provide housing and other services.
- Develop a strong commitment to prevention.
- Provide integrated services to people with multiple disabilities.
- Provide all these services under the guidance and advice of local citizens who are appointed by elected officials.

E. Funding

From passage of the original enabling legislation in 1968 to the present, services provided by CSBs have been funded through a matching grant mechanism in which certain local funds, local government appropriations, charitable contributions, and specific types of in-kind donations match state general funds. Although the match was originally a 50:50 ratio, subsequent legislation lowered local government share to 25 percent and ultimately to 10 percent to reflect and provide the ability to recognize that certain areas, especially urban, have more resources to contribute than do some rural areas with fewer resources. In the 1980s, state contributions hit the highest ratio of state:local contributions, averaging about 63 percent state and 37 percent local. 1991 saw a drop in state contributions, due mainly to the implementation of the Medicaid State Plan Option (SPO) initiative which uses state funds as a 49 percent match for the federal share of Medicaid SPO fees. The local match percentage, however, has continued to increase and now stands at an average of almost 46 percent. Several other funding sources play an important role in funding local services, including federal grants,

expansion of Medicaid coverage, and fees. Fees, resulting primarily from the expansion of the Medicaid State Option Plan, as well as those charged to parties such as third-party insurers, direct client, schools, and courts has grown as a revenue source by approximately 263 percent since FY 1990.

The Code of Virginia (§ 37.1-199) stipulates the factors that the Department shall consider in allocating state funds for community services. These factors include:

- the total amount of funds appropriated to the Department for this purpose;
- the total amount of funds requested by the local CSB;
- the financial abilities of all of the local governments participating in the board to provide funds required to generate the requested state match;
- the type and extent of programs and services offered or planned by the local CSB;
- the availability of services provided by the local CSB in the areas served by it; and
- the ability of the services provided by the local CSB to decrease financial costs to the Department and increase the effectiveness of treatment by reducing state facility admissions.

In addition, the Appropriations Act contains factors that the Department must consider. For example, the Act requires CSBs to participate in the Medicaid State Plan Option initiative or not be eligible for funds. It also prohibits using additional state appropriations to replace local matching funds.[3]

In the early history of CSBs, funds were allocated depending on the ability to provide the required match in funds and the ability to respond to legislative or departmental program initiatives. In recent years this has evolved to allocations based on maintenance of current levels of service given the large amount of unmet needs and the implementation of new program initiatives. Today, funding formulas are used primarily to allocate new or additional funds.

Perhaps one of the most-discussed issues which evolved in the joint subcommittee was the two-pronged funding of mental health services - the division of state funds between the state facilities and the local CSBs. Recent figures show that while facilities serve 6.1 percent of the mental health client population, approximately 93.9 percent were served through the CSBs. On the other hand, funding (state dollars) for facilities accounted for 68.1 percent ($385.7 million) of the state mental health budget with 5.3 percent ($30.2 million) going to central office support and 26.6 percent ($150.6 million) supporting the CSBs. (After adding in all federal, state, local and fee dollars, the

[3] "Funding Local Mental Health, Mental Retardation and Substance Abuse Services," prepared for the use of the Joint Subcommittee Studying the Effects of Deinstitutionalization, 1994. (See Appendix C.)

facilities account for 49.7 percent of the total mental health, mental retardation and substance abuse services budget while services provided through CSBs account for approximately 46.7 percent of the total budget.) Current budget allocations clearly divide the funding for facility and CSB programs and allow for no easy transfer across funding lines to follow the client and "reinvest" the money saved by avoiding institutionalization. As previously stated, institutionalization of appropriate clients will always be a necessary part of the continuum of mental health care, but what is needed is a methodology to allow for more creative use of the dollars available for such care.

"Single-stream funding" which works to allow the funding for services to follow the consumer to wherever services are available or are needed was felt to be the major issue under consideration. Other states have wrestled with this phenomenon and some have embarked upon ambitious programs to "reinvest funds" realized by the downsizing of institutions, but the joint subcommittee feels that a more moderate, gradual approach is necessary to ensure that current individuals with mental health, mental retardation and substance abuse services needs as well as those on waiting lists are provided uninterrupted services and that the transition in program funding be an orderly, responsible, and accountable process while maintaining necessary facility services.

The joint subcommittee, in response to the needs of both the population of consumers as well as the infrastructure of government, which has the responsibility to provide care, supports the following general and specific concepts about the provision of community-based mental health care to persons with mental illness, mental retardation and substance abuse problems in the Commonwealth.

F. Concepts and Principles

General concepts

- Community-based planning and decision-making about the provision of MHMRSA services should drive the system.
- In accordance with § 37.1-10, the State Mental Health, Mental Retardation and Substance Abuse Services Board is the policy-making body for the publicly-financed mental health, mental retardation and substance abuse system.
- Community-based planning should rely on the continuation and enhancement of the relationship among consumers, families, local government, providers, and others who have a stake in the provision of mental health care.
- Funding for mental health, mental retardation and substance abuse care should remain at least constant or increase to provide additional basic services to those in need who remain underserved or unserved.
- Any changes in the provision of MHMRSA services should be done in a manner that is rational, accountable and deliberate.

- Implementation of any changes in the MHMRSAS system should be phased-in in a deliberate fashion to alleviate or avoid any adverse effects on not only consumers, but also the system itself.
- The working relationship among all parties involved in the provision of MHMRSA services should be encouraged and enhanced in order to provide consumers with the best services available.
- While recognizing that managed care principles have many positive attributes which may enable the system to provide better and more accountable care with better outcomes to more individuals, the joint subcommittee feels that the current CSB system, with appropriate training and available systems, can and should continue to make decisions and provide for the distribution of public MHMRSA services using appropriate managed care principals.

Examples of managed care technologies utilized by the private sector and in other states include performance and outcome incentives, case rate or capitated payment mechanisms, and utilization management strategies for priority populations. Examples of enhanced accountability mechanisms include individualized encounter and outcome data, output and outcome measures, comparable cost information, consumer satisfaction and participation indicators, and analysis of consumer access to services.

Specific Concepts

In response to the need to develop alternative methods of providing care to individuals with mental illness, mental retardation and substance abuse problems in the Commonwealth, the joint subcommittee heard presentations from numerous sources. The subcommittee, as its major recommendation to the House Appropriations and Senate Finance Committees, recommends that the following guiding principles and operational concepts serve as the vision and basis for the future publicly-funded mental health, mental retardation and substance abuse services in the Commonwealth:

Guiding Principles

- Community-based planning and decision-making should drive the system.
- The system should be consumer oriented.
- Mental Health, Mental Retardation and Substance Abuse (MHMRSA) services should be fully integrated and well coordinated with other community services.
- A single, local organization should be responsible for the management and coordination of MHMRSA services.
- Public finding for MHMRSA services should be fully integrated.
- The MHMRSAS system should redirect and reinvest resources as necessary to address consumer need.

- A network of public and private providers with sufficient expertise and capacity is essential.
- The publicly-funded MHMRSAS system should be outcome-oriented.
- The system should contain cost.
- The cost of services should not be shifted to local government.

Operational Concepts

- Community Services Board should remain the single local organization responsible for the publicly-funded MHMRSAS system.
- All public funds that support the MHMRSAS system should be integrated at the local level through the CSB.
- Public MHMRSAS funding should be allocated based on eligible populations.
- Eligible populations should be defined.
- CSBs should provide services through a network of CSB and private providers, including the purchase of services from state facilities.
- MHMRSA services should be evaluated based on agreed-upon outcomes.
- Standards regarding access to services should be established.
- The CSBs should accept responsibility and risk for services to eligible populations.
- The development of public/private partnerships should be continued.
- The state should retain the responsibility for persons found not guilty by reasons of insanity or incompetent to stand trial.
- The MHMRSAS system should maximize Medicaid for persons with mental disabilities.
- The MHMRSAS system should be evaluated [on an ongoing basis] to determine effectiveness.

(A detailed explanation of these principles and operational concepts can be found in Appendix D.)

IV. BUDGET RECOMMENDATIONS

To begin implementation of many of the concepts endorsed by the joint subcommittee, the following items were adopted by the 1996 General Assembly in Chapter 912 of the Acts of Assembly (Budget):

A. Department of Medical Assistance Services

Item 322 (D.4.)

Effective on or after July 1, 1996, the Virginia Medical Assistance Program shall provide expanded state plan option services for community-based mental health, mental retardation and substance abuse services to be provided by Community Services Boards.

Item 322 (G)

It is the intent of the General Assembly that upon the repeal of Title XIX of the Social Security Act and enactment of Title XXI of the Social Security Act, which is expected to establish state MediGrant programs, or upon passage and signature of any federal legislation that makes or permits reductions in funds or services in the Medicaid program, the Board of Medical Assistance Services shall develop a plan for providing Medicaid assistance to the poor, in compliance with the federal changes. Prior to the development of such plan, the Department shall conduct a public education program to explain the federal changes to the recipient community, and shall include a mechanism for obtaining public input. The Department's plan shall be presented to the Chairmen of the House Appropriations Committee, the House Health, Welfare and Institutions Committee, the Senate Finance Committee, the Senate Committee on Education and Health, the Commission on Federal Block Grant Programs, and the Joint Commission on Health Care by October 1, 1996, if the federal changes are approved by that date. No changes in the current Medicaid state plan, related to these federal changes, shall be made prior to the 1997 General Assembly's approval of the Department's plan.

Item 322 (L.1.)

The Department of medical Assistance Services shall delay the expansion of the MEDALLION II managed care, capitated program into the Northern Virginia region until May 1, 1997.

Item 322 (L.2.)

With the aid of an outside party that has expertise in services for the mental health, mental retardation, and substance abuse populations, the Department, working jointly with the Department of Mental Health, Mental Retardation and Substance Abuse Services, Community Services Boards, providers, consumers and family members, local governments and health maintenance organizations in the Northern Virginia region, shall develop alternative patient-focused models for the inclusion of the mentally disabled population in a mandatory managed care product. One of the alternative models shall provide for the administration, delivery and funding for behavioral health care to be separate from all other health care. The analysis of each model should include the advantages and disadvantages of the model, both financial and administrative, for the population involved and for Virginia's publicly funded mental health system and

implementation strategies for each. The workplace for the effort and an interim and final report shall be submitted to the Joint Commission Studying the Publicly Funded Mental Health System and to the Chairmen of the following committees: House Appropriation; House Health, Welfare and Institutions; Senate Finance; Senate Education and Health; and the Joint Commission on Health Care. The Department of Medical Assistance Services shall submit an interim report by September 1, 1996, and the final report by December 18, 1996.

Item 322 (L.4.)

The Department of Medical Assistance services shall evaluate the feasibility of expanding the MEDALLION II program to include medically underserved areas in the Tidewater region and surrounding areas. The Department shall submit a report of its findings and recommendations to the Chairmen of the following committees: House Appropriations; House Health, Welfare and Institutions; Senate Finance; Senate Education and Health, and the Joint Commission on Health Care by October 1, 1996. It is the intent of the General Assembly that the Department shall not further expand into the Tidewater region until May 1, 1997, and shall incorporate the findings of the models being constructed for Northern Virginia, as specified in paragraph 2 above.

B. Department of Mental Health, Mental Retardation and Substance Abuse Services

Item 327 (C)

The Department, with input from the State Board, Community Services Boards, consumers and family members, advocates, and local governments, shall identify priority populations and related funding strategies and develop and implement Community Services Board performance measures that assess outputs and outcomes. Performance measures shall be developed for all services, and outcome measures shall be identified for selected priority populations. These output and outcome measures shall be developed, implemented, and evaluated on a pilot basis in fiscal year 1997 and fully implemented as part of all Community Services Board performance contracts in fiscal year 1998. The results of the pilot project shall be presented to the Secretary of Health and Human Resources not later than December 1, 1996.

Item 327 (E)

The Department, in cooperation with Community Services Boards, shall procure consulting assistance in the development of a plan to improve fiscal and performance information on mental health, mental retardation and substance abuse services provided by or under contract with Community Services Boards as well as by state mental health and mental retardation facilities. The plan shall also include, but not be limited to, collection of data on individual clinical outcomes, quality of care, and other measures for assuring quality and accountability in the provision of services to mentally disabled persons. The plan shall be submitted to the Chairmen of the House Appropriations and

Senate Finance Committees, the Joint Subcommittee to Study the Publicly Funded Mental Health System, and the Secretary of Health and Human Resources by December 1, 1996.

Item 327 (F)

The Department, in cooperation with Community Services Boards, consumers and family members, advocates, and local governments, shall work with the Joint Subcommittee Studying the Publicly Funded Mental Health System to develop recommendations to the 1997 General Assembly for reinvestment of: fiscal year 1997 general and special fund balances, savings from operating efficiencies, unbudgeted revenues, and proceeds from restructuring activities. Recommendations shall include a plan for improving the quality of care in community-based and state facility services and for expanding capacity and reducing waiting lists in community services. The plan shall be submitted to the 1997 General Assembly for approval.

Item 333 (H)

Out of this appropriation, $1,600,000 in the second year from the general fund shall be provided for state hospital census reduction/managed care projects to serve individuals with serious and persistent mental illness and multiple hospital admissions. Funding may be used for similar projects that serve mentally retarded persons in state training centers. The Department, in cooperation with Community Services Boards, consumers and family members, advocates, and local governments, shall plan the projects and report the plan to the Joint Subcommittee Studying the Publicly Funded Mental Health System prior to implementation.

V. APPENDICES

APPENDIX A

Department of Mental Health, Mental Retardation and Substance Abuse Services

Proposed Bed Reduction Plan

Department of Mental Health, Mental Retardation and Substance Abuse Services

Proposed Bed Reduction Plan

Item 409 of the 1994 Appropriation Act (Chapter 966) Acts of the Assembly

Timothy A. Kelly, Ph.D.
Commissioner

October 1, 1994

Department of Mental Health, Mental Retardation and Substance Abuse Services

Bed Reduction Plan

Item 409 of the 1994 Appropriation Act (Chapter 966) Acts of the Assembly

Table of Contents

I. Introduction

Purpose

The 1994 General Assembly, in Item 409 of the 1994 Appropriation Act called for a reduction in the Department of Mental Health, Mental Retardation and Substance Abuse Services budget. The Act called for bed reductions at selected facilities operated by the Department. The Appropriation Act stated that before FY 96 budget reductions were to take effect at several facilities -- Eastern State Hospital, Western State Hospital, and Southside Virginia Training Center -- the Department was required to submit bed reduction plans to:

- outline the steps to be taken to reduce beds,
- profile the patients or residents to be discharged,
- determine the community services required by these individuals, and
- assess the availability of these services in the communities to which these individuals would be returning.

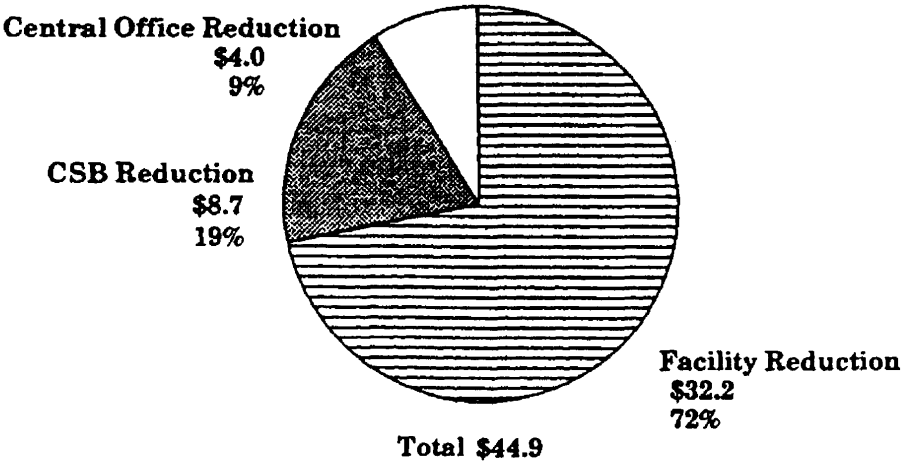
This report responds to this Appropriation Act requirement.

History of Previous Budget Reductions

The facility bed reductions proposed in the 1994 Appropriation Act were in addition to significant reductions experienced in the preceding four years. Between 1990 and 1994, the Department of Mental Health, Mental Retardation and Substance Abuse Service sustained $44.9 million in total general fund and non-general fund budget reductions. An additional $23.7 million in special revenues and balances reverted to the general fund. This amounted to a total reduction to Virginia's mental health, mental retardation, and substance abuse services system of $68.6 million. The following chart illustrates that over 70% of the $44.9 million reduction was in the facilities:

Total General & Non General Fund 1990-1994 Budget Reductions for the Central Office, Community Services Boards, and Facilities

Dollars in Millions



Facility budget reductions were realized through the following actions:

1990-92

- Closed Western State Hospital Geriatric Center (130 Beds)
- Merged Virginia Treatment Center for Children With the Medical College of Virginia
- Consolidated Western State Hospital and DeJarnette Support Services

1992-93

- Closed Eastern State Hospital Adolescent Unit (40 Beds)
- Reduced Eastern State Hospital Medical Center (25 Beds)
- Closed Western State Hospital Alzheimers Unit (20 Beds)
- Reduced Western State Hospital Laundry
- Reduced Central Virginia Training Center Geriatric Unit (50 Beds)

Agency 1994-1996 Budget Reduction Contingency Plans

In September 1993, the Department of Mental Health, Mental Retardation and Substance Abuse Services prepared a Budget Reduction Contingency Plan for the 1994-96 biennium. This plan was required to:

- Permanently reduce state government operating costs, services, and employees;
- Reduce the ongoing commitment of resources for selected state programs and institutions, including state hospitals and training centers; and
- Address a projected budget shortfall facing the Commonwealth.

The Department's budget reduction for the 1994-96 biennium was $11.5 million in general funds. To achieve this target, the Department proposed permanent census reductions at its large facilities and cuts in the central office budget, avoiding cuts at the smaller institutes, training centers, and two freestanding geriatric centers. Under this plan, approximately one half of the cost of facility beds to be closed would be available for transfer to the community to offset facility reductions. The following table outlines the Department's proposed budget reductions (in millions):

Original Proposed Actions	FY 95	FY 96	Biennium
Reduce Contracts and Central Office Costs	$ 1.000	$1.000	$ 2.000
Reduce Community Services Boards by 1%	1.400	1.400	2.800
Focused Closure of State Mental Health and Mental Retardation Facility Beds	2.800	3.650	6.450
Use Non General Fund Balances on 6/30/94	0.225	0	0.225
TOTAL GENERAL FUNDS	$ 5.425	$ 6.050	$ 11.475

Agency Budget Reduction Plan Limitations

The Department's plan to cut its budget by $11.5 million during the 1994-96 biennium held significant risks for the services system if its proposed reductions had been implemented within the established timeframe and available resources. This plan differed from prior facility bed reductions of geriatric and adolescent beds because existing capacity within the community and other state facilities could absorb those cuts without major adverse effect on overall service capacity. This was no longer the case. There were no more facility areas to merge and limited flexibility to close facility beds without reinvesting adequate funding for community services.

In its budget reduction planning, the Department recognized that successful facility bed reductions in Virginia and other states were based on the:

- Availability of adequate funding for community services to offset facility reductions while maintaining the quality of care provided in facilities;
- Continued investment of resources in community programs to address the need for a continuum of effective services; and
- Transition funding to provide start-up services for discharged patients.

Although the Department's reduction plan was consistent with its long term goal of reducing the size of older and larger state facilities, time constraints and resource requirements precluded these three prerequisites from being fully incorporated into the budget reduction plan.

In fact, a number of serious limitations with the Department's proposed budget reduction plan were identified, including:

- The very short time frame available to develop the budget reduction contingency plan did not allow for broad-based participation by consumers, advocates, and service providers in assessing the impact of the proposed reductions.
- Because the overall services system was underfunded, sufficient resources were not available to provide a continuum of effective services in communities and to assure quality inpatient care in state facilities.
  - The census at several state mental hospitals has been increasing and some programs are now operating over capacity.
  - In several facilities, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Medicaid, and U.S. Department of Justice Civil Rights for Institutionalized Persons Act (CRIPA) reviews have identified staffing deficiencies and recent events have demonstrated security issues.
  - There continue to be waiting lists for essential community services.
- The plan's proposed community funding was not adequate to offset the loss of facility beds.

The 1994 General Assembly recognized these limitations and took the following actions with respect to the Department's budget reduction plan:

- restored the proposed reductions for community services boards and Central State Hospital;
- deferred, until FY 96, the proposed bed reductions at Eastern State Hospital, Western State Hospital, and Southside Virginia Training Center, contingent upon the acceptance of a Departmental assessment of the impact of the proposed reductions and the availability and cost of community services required for affected patients and residents; and
- agreed to move forward with the Central Office reductions and the proposed bed reductions at the Central Virginia Training Center.

With the exception of Central State Hospital, all of the original FY 96 facility bed reductions, or $3.5 million, remained in effect. There are no plans to revise the implementation of the$1.6 million at Central Virginia Training Center, which is not part of the Item 409 study. Therefore, this plan will address Appropriation Act Item 409 requirements related to the $1.9 million general fund reversion, as reflected in the table below.

Appropriation Act Item 409 Plan Requirements

To achieve the general fund savings and related transfers for community services, the following total facility budget reductions in general funds (GF) and non-general funds (NGF) would be required in FY 96 for Eastern State Hospital (ESH), Western State Hospital (WSH) and Southside Virginia Training Center (SVTC). For Southside Virginia Training Center, it also will be necessary to reduce non-general fund revenues generated from Medicaid. For each facility, reductions, savings to the general fund, and funds to be transferred to the community required in the 1994 Appropriation Act follow. Dollar amounts are in millions.

Facility	Beds To Be Lost	FY 96 Facility Reduction In Millions			Net General Fund Reversions	Funds Transferred for Community Services
		GF	NGF	Total		
ESH	30	$ 2.100	---	$ 2.100	$ 0.600	$ 1.500
WSH	75	$ 1.750	---	$ 1.750	$ 0.500	$1.250
SVTC	35	$ 1.134	$ 0.800	$ 1.934	$ 0.800	$ 0.334
TOTAL	140	$ 4.984	$ 0.800	$ 5.784	$ 1.900	$ 3.084

Item 409 required that by October 1, 1994, the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services present to the Governor and Chairmen of the House Appropriations and Senate Finance Committees a plan, if the remaining bed reductions proposed for fiscal year 1996 are to be implemented. The plan shall include a determination concerning the adequacy of community supports for discharged patients and a profile of the patients proposed for discharge. The plan shall be coordinated with the study required by House Joint Resolution 139 [creating the Joint Committee on Deinstitutionalization].

II. Facility Bed Reduction Plans

Facility Budget Reduction Planning

To respond to the requirements outlined in Item 409, the Department and each of the affected facilities completed the following objectives:

- determined the feasibility of and requirements for future bed reductions at state mental health and mental retardation facilities;
- developed a profile of patients to be discharged or diverted from admission with bed closings; and
- determined the adequacy of community supports for discharged persons and the need for additional resources.

The Department and facilities concluded that the most viable approach to achieve the bed reductions proposed at Eastern State Hospital, Western State Hospital, and Southside Virginia Training Center was to use the federal Medicaid Mental Retardation Home and Community Based Waiver program. This program allows a State to use Medicaid funding for specific community services as alternatives to institutional care. Individuals with mental retardation at the two state hospitals and the training center have been determined to meet eligibility requirements for the waiver. There are several major advantages to the Commonwealth for using the waiver.

- Community services support through the waiver can be tailored to each individual's needs and circumstances.
- Direct cost savings in facilities would be transferred to communities and matched on a 50% state/50% federal basis, providing for the full cost of community services.

The original plan was to reduce admission beds at Western State Hospital (75 beds) and Eastern State Hospital (30 beds). By changing the focus of the revised plan from admissions beds to long-term beds serving individuals with both mental retardation and mental illness (dual diagnoses), the Department was able to change the number of beds to be closed from 140 to 124. This revised plan follows.

Revised Bed Reduction Plan

(Dollars in Millions)

	# Beds Lost	# Disch.	FY 96 Total Facility Reduction			General Funds Reduced	Amount for Community Services		
			GF	NGF	Total		GF	Medi-caid	Total
ESH	60	38	$ 1.93	---	$ 1.93	$0.60	$ 1.33	$ 1.33	$ 2.66
WSH	28	28	$ 1.48	---	$ 1.48	$ 0.50	$ 0.98	$ 0.98	$ 1.96
SVTC	36	12	$1.22	$ 0.71	$ 1.93	$ 0.80	$ 0.42	$ 0.42	$ 0.84
TOTAL	124	78	$ 4.63	$ 0.71	$ 5.34	$1.90	$ 2.73	$ 2.73	$ 5.46

To achieve a reduction of 124 beds,78 patients and residents will be discharged to the community. The remaining patients and residents will be transferred to other units in the state facility system.

It is anticipated that a per capita amount of approximately $70,000 will be required to support a plan care for each individual who has been identified at Eastern State Hospital, Western State Hospital, and Southside Virginia Training Center. This $70,000 per patient rate would be provided through a $35,000 general fund transfer from the facility and $35,000 of federal Medicaid matching funds.

In July 1994, the Department requested that each of the three facilities work with community services boards in its service area to develop a plan to meet the bed reduction targets. Each facility assessed the extent to which specific programs or units would be affected in terms of the numbers of beds closed, staffing reductions, and cost savings.

Additionally, the facilities and community services boards identified the number and developed a profile of patients or residents who would be affected. With this information, they projected the level and costs associated with providing community services and supports. These reduction plans were submitted to the Department on August 19, 1994 for review, analysis, and incorporation into the final report.

Eastern State Hospital Bed Reduction Plan

Bed Reduction Plan:

Over the past year, Eastern State Hospital has been planning to close Building 30, a 60 bed long-stay program for patients who have been dually diagnosed with both mental retardation and mental illness. In June, 1993, Building 30 was fully occupied. Since then, 22 patients have been transferred to Southside Virginia Training Center. Five patients have been discharged; two to community waiver placements and three to other placements or to their families while awaiting waiver placements. Currently, 33 individuals with dual diagnoses remain in Building 30.

Successful closure of Building 30 is contingent upon several factors:

- developing appropriate alternate community services prior to the discharge of patients and maintenance of these services when facility beds are no longer available,
- eliminating new, long-term admissions of individuals with mental retardation diagnoses to Eastern State Hospital.
- providing training for community services board emergency services staffs and developing an internal program for expediting appropriate discharges of people with mental retardation who are involuntarily admitted for treatment of an acute psychiatric problem,
- making available community census reduction, and bed purchase/ diversion funds to reduce admissions of people with mental retardation to Eastern State Hospital,
- increasing emphasis on intensive case management services to reduce the length of stay for crisis stabilization admissions to Eastern State Hospital, and
- collaborating with and supporting Southeastern Virginia Training Center in the development of a crisis stabilization unit for persons with mental retardation.

To accomplish the goal of closing Building 30, the 33 patients who are now residing in this building will be discharged under the waiver program or transferred to other units at Eastern State Hospital or to a state training center. The following table lists the number of individuals proposed to be discharged from Building 30 by community services board.

CSB	Number	CSB	Number
Chesapeake	3	Norfolk	8
Colonial	1	Portsmouth	1
Eastern Shore	1	Virginia Beach	7
Hampton-Newport News	9	Western Tidewater	3

Prospective community services providers have been identified for 24 of the 33 individuals. Three individuals will be transferred to Southside Virginia Training Center for subsequent community placements at a later time. Families of two persons continue to oppose community placements and discharge planning has been more complex. Four individuals require additional psychiatric stabilization before further discharge planning can occur.

To close Building 30, the following actions will occur:

- Phase 1 -- Six female patients identified as eligible for the Home and Community Based Waiver program will be temporarily transferred to other Eastern State Hospital Units while awaiting community placements.

  Two patients from Newport News will be discharged into temporary community placements and provisions will be made for staff support as a preliminary to placement in a group home with day services.

- Phase 2 -- Eight patients with mental illness diagnoses will be transferred to Eastern State Hospital's Continuing Rehabilitation Program.

  The two highest priority waiver consumers from Norfolk will be discharged and placed in a community residential program. These individuals will require residential and day services.

  The remaining male waiver population will be consolidated into one 15 bed ward.

- Phase 3 -- All remaining patients residing in Building 30 will be discharged or transferred to prospective placements.

- To whatever extent possible, staff will be redeployed to other units to replace staff lost through attrition.

Profile of Patients and Services Requirements:

The majority of the individuals to be discharged from Building 30 have a dual diagnosis. Their Axis II Mental Retardation diagnosis ranges from mild to severe. All of these individuals have psychiatric conditions that require medications. Many also receive treatments and medications for medical conditions such as epilepsy, diabetes, hypertension, and glaucoma. They will require intensive, structured 24 hour support and services in the community, including residential care, day support, vocational services, behavioral intervention, and assertive and targeted case management. Behavioral disorders are frequently exhibited by many of these persons.

Recommended supports for each of these individuals would consist of highly supervised residential options and individualized day support options. Most would also require Behavioral Consultation to develop behavioral protocols and assertive case management to prevent crisis situations. The table on page 9 identifies community services that will be required to support the 38 individuals from Building 30:

Services	Number Needing Service	Projected Annual Service Costs Per Person (State Share)
Residential Settings		
Supported Living/ Supervised Apartments	24	$ 24,000
Group Homes	14	$ 25,500
Day Support		
Alternative Day Support	9	$ 8,000
Supported Employment	9	$ 8,000
Psychosocial Rehabilitation	20	$ 8,000
Targeted Case Management	38	$ 2,105 (SPO)*
Medical Follow-up	38	Clinic Option Medicaid**
Psychiatric Follow-Up	38	Clinic Option Medicaid**
Crisis Stabilization/Assertive Case Management	38	Clinic Option Medicaid**
Therapeutic Consultation		
Behavioral Intervention	28	$ 1,500
Behavioral Intervention	10	$ 750***
OT/PT	10	$ 750***

* The Medicaid State Plan Option (SPO) will cover case management services

**The Medicaid Clinic Option will cover psychiatric and medical services.

*** The Waiver allows a maximum of $1,500 per persons for all therapies. Most persons (50) will need behavioral interventions only, but ten have brain injuries or other fine motor physical disabilities and will require OT/PT as well.

Western State Hospital Bed Reduction Plan

Bed Reduction Plan:

The original budget reduction target of 75 beds at Western State Hospital did not fully account for the operational capacity needs of Northwestern Virginia (Region I) and Northern Virginia (Region II), which comprise the hospital's service area. A reduction of 75 additional beds, when considered in light of previous reductions of 150 beds at Western State Hospital and the substantial projected population growth in the regions served by the hospital, would not be practical or in the best interest of the Commonwealth.

There is no practical means by which Western State Hospital can be reduced by 75 beds within FY 96 without seriously reducing the availability of public mental health services for the region and causing unacceptable and unsafe overcrowding at the facility. Currently, the hospital's in-house population often exceeds its operational capacity of 490 beds, requiring the use of up to ten temporary beds set up in day rooms on admissions wards. The hospital has relied upon the purchase of short-term acute psychiatric beds from other providers in the region to prevent the number of temporary beds from exceeding ten, which was the situation in the past.

As an alternative, the Department proposes that the Life Skills Service Level I Ward B6 (28 beds), which serves patients with exceptionally long lengths of stay at Western State Hospital, be closed during FY 95. The successful downsizing of Western State Hospital is contingent upon:

- developing appropriate alternate community services prior to discharging patients on Ward B6 and maintaining these services when facility beds are no longer available;
- eliminating new, long-term admissions of individuals with mental retardation diagnoses to Western State Hospital; and
- maintaining quality inpatient services to effectively respond to the increasing proportion of treatment resistive and volatile patients who will be concentrated in a smaller number of wards at Western State Hospital.

At Western State Hospital, 45 long-stay individuals, many of whom have both mental retardation and mental illness (dual diagnoses), are potentially eligible for community placements under the Medicaid Mental Retardation Home and Community Based waiver program. The hospital has estimated that 28 of these potentially eligible long-stay patients could be transferred to community settings if appropriate support services were created for these individuals. The following table lists these potentially eligible individuals by community services board:

CSB	Number	CSB	Number
Alexandria	4	Loudoun	1
Arlington	1	Northwestern	5
Blue Ridge	4	Prince William	1
Central Virginia	1	Rappahannock	4

CSB -- Continued	Number	CSB	Number
Crossroads	1	Rappahannock/Rapidan	4
Danville	1	Region Ten	1
Fairfax-Falls Church	9	Rockbridge	3
Harrisonburg-Rockingham	2	Valley	3

The following implementation steps are proposed to close Ward B6:

- Phase 1 -- Ten individuals with primary diagnosis of mental retardation will be placed in community group homes.
- Phase 2 -- Ten individuals with a dual diagnosis of both mental illness and mental retardation will be placed in supported living alternatives.
- Phase 3 -- Eight individuals with a dual diagnosis of both mental illness and mental retardation and challenging behaviors will be placed in highly supervised living alternatives.
- To whatever extent possible, staff will be redeployed to other units to replace staff lost through attrition.

Profile of Patients and Services Requirements:

The 28 individuals to be discharged from Ward B6 have long lengths of stay within state facilities, primarily Western State Hospital. The 28 residents in question range in age from 21-63. Ten individuals have a mental retardation diagnosis only (i.e., no mental illness diagnosis). Seven of these individuals have both mental retardation and a hearing impairment.

Most of these individuals have been at Western State Hospital at least four years; one person has been there 40 years. Five individuals have been on the waiting list for admission to the Northern Virginia Training Center, some for as long as ten years. Western State Hospital is not an appropriate placement for these individuals.

These individuals will require intensive 24 hour structured programs. Their services support needs include:

- residential small group and supported living/supervised apartments,
- behavioral consultation (many patients have behavioral issues),
- day support community integration, and real work,
- sign language interpreters for deaf residents in counseling and residential environments,
- speech therapy,
- medical supports (many residents have high medical needs: diabetes, etc.),
- transportation, and
- community crisis intervention teams to reduce the need for future inpatient placements.

Community services identified as being needed by these individuals include:

Services	Number Needing Service	Projected Annual Service Costs Per Person (State Share)
Residential Settings		
Group Homes	16	$ 25,500
Supported Living	12	$ 24,000
Day Support		
Alternative Day Support	5	$ 8,000
Supported Employment	20	$ 8,000
Psychosocial Rehabilitation	5	$ 8,000
Targeted Case Management	28	$ 2,105 (SPO)*
Medical Follow-up	28	Clinic Option Medicaid**
Psychiatric Follow-Up	28	Clinic Option Medicaid**
Crisis Stabilization	28	Clinic Option Medicaid **
Therapeutic Consultation		
Behavioral Intervention	21	$ 1,500
Speech/Audiology Services	7	$ 1,500

* The Medicaid State Plan Option (SPO) will cover case management services

**The Medicaid Clinic Option will cover psychiatric and medical services.

Southside Virginia Training Center Bed Reduction Plan

Bed Reduction Plan:

Since Southside Virginia Training Center is primarily funded through Medicaid revenues, the targeted reduction of 35 beds and 35 positions required by the Appropriation Act will not result in savings of $1,934,000. To achieve these savings, the training center would actually have to close 90 beds and reduce its staff by 72 positions. The reason for this increase is due to the loss of federal Medicaid funds.

Such a reduction would be drastic and could prevent the successful implementation of the bed reduction plans proposed for Eastern State Hospital and Western State Hospital that close units for long-stay patients with both mental retardation and mental illness. A reduction of 90 beds at Southside Virginia Training Center would eliminate its ability to admit persons with mental retardation and mental illness who previously would have been served at Eastern or Western State Hospitals.

As an alternative, the Department proposes that the $800,000 general fund reduction for Southside Virginia Training Center be restored, of which $420,000 would be available to the communities as Medicaid match for individuals to be discharged through the closure of Building 10, Unit III on the North Campus (36 beds). The remaining $380,000 would be restored in Southside Virginia Training Center's budget to assure that services are available for any individuals with dual diagnoses whose discharges under Eastern State and Western State Hospital's bed reduction plans have proven to be unsuccessful.

As a result of the closure of Building 10, twelve residents would be discharged to the community and the remaining residents would be relocated within the facility. This will result in the reduction of 25 staff who, to whatever extent possible, would be redeployed to other units to replace staff lost through attrition. Successful closure of Building 10 is contingent upon:

- A planned transitional process involving the Center and the community services boards it serves will be developed.
- Required savings can best be accomplished by closing buildings on the Southside Virginia Training Center North Campus, in accordance with the Center's Comprehensive Master Site Plan.

The community services boards served by the Southside Virginia Training Center have demonstrated genuine interest in working collaboratively with the Center to develop community options for clients contingent upon the availability of start-up match funds. The following table lists these potentially eligible individuals by community services board.

CSB	Number	CSB	Number
Chesterfield	2	Henrico Area	1
Crossroads	1	Richmond	4
District 19	1	Southside	3

Profile of Residents and Services Requirements:

For the twelve residents projected for discharge, one has profound mental retardation, five have severe mental retardation, five have moderate mental retardation, and one has mild mental retardation. They range from 35 to 45 years old. Two individuals are non-ambulatory (requiring wheelchairs), two have hearing impairments, two are blind, and four have speech impediments. Nine of the twelve individuals have challenging behaviors.

All of these individuals will require structured and intensive 24 hour services and supports. These services and supports will be necessary for them to maintain activities of daily living such as housekeeping, budget, meal planning, and personal hygiene. The following table summarizes:

Services	Number Needing Service	Projected Annual Service Costs Per Person (State Share)
Residential Settings		
Group Homes	12	$ 25,500
Day Support/Employment		
Day Health and Rehabilitation	10	$ 8,000
Supported Employment	2	$ 8,000
Targeted Case Management	12	$ 2,105 (SPO)*
Medical Follow-up	8	Clinic Option Medicaid (SPO)**
Therapeutic Consultation		$ 1,500 Maximum Per Year for All Therapeutic Consultation Services
Behavioral Intervention	8	
Occupational Therapy	1	
Physical Therapy	6	
Speech Therapy	4	
Audiology Services	2	
Vision Care	2	

* The Medicaid State Plan Option (SPO) will cover case management services.

** The Medicaid Clinic Option will cover psychiatric and medical services.

III. Suggestions for Continuing Bed Reduction Momentum

The Department offers an approach to further enhance facility bed reductions by purchasing Clozaril or other similar medications such as Risperidone for patients who have not responded well to other treatments. The expanded use of these medications will enable the hospitals to discharge long-term patients who were previously too ill to be discharged and to continue to reduce their operating capacities.

Consistent with the scientific literature and the published findings of other state systems, the experience at Western State Hospital shows that Clozaril has improved symptoms, dramatically reduced aggressive behavior, and allowed the discharge of long term patients previously too ill to leave the hospital. There are many examples of "Clozaril miracles," where patients confined to inpatient psychiatric care for decades have been able to return home, find employment, and improve the quality of their lives.

Data reviewed in late 1993 revealed that of the 75 patients who had received Clozaril at Western State Hospital, 28 (37%) had been discharged and only two returned. This was much higher than the overall discharge rate for long-term care programs. Few of these patients could have been successfully discharged without Clozaril.

IV. Conclusion

One of the priorities of the Department is to build a continuum of community services that meet the needs of Virginians with mental disabilities in the most humane and efficient way possible. The bed reduction plan proposed by the Department provides an opportunity to begin this needed process.

The bed reduction plan proposed for Eastern State Hospital, Western State Hospital, and Southside Training Center is consistent with the long range directions of the Department of Mental Health, Mental Retardation and Substance Abuse Services. Its focus is consistent with the directions established by the General Assembly in Item 409 of the 1994 Appropriation Act. Major benefits of this plan include:

- This plan maintains the intent of the General Assembly to reduce the size of the largest mental health and mental retardation facilities and to expand community programs. Each of the facilities has identified individuals who are now ready to be discharged if appropriate community services and supports were available.
- It maximizes resources available to the Commonwealth. By using the federal Medicaid Mental Retardation Home and Community Based Waiver, the Department should have sufficient resources to fund needed community services for these individuals who are ready to be discharged.
- By matching state general fund savings with federal Medicaid waiver funds, the plan corrects potential problems related to the adequacy of community resources that may have arisen if the Department's initial proposal had been implemented, and actually increases the total funding for community services.
- The plan addresses a long-standing priority to move individuals who have dual diagnoses of mental retardation and mental illness out of state mental health facilities and integrate them in more appropriate services, either in their communities or in a training center.
- Finally, this plan offers a proposal to further enhance bed reductions in state mental health facilities by purchasing Clozaril or other similar medications such as Risperidone.

In conclusion, this is a much more viable plan than the proposal submitted to the 1994 General Assembly. Its implementation will allow units to be closed in selected facilities, assure community services are in place for patients and residents who are discharged form these units, and retain adequate beds and funds at Southside Virginia Training Center to assure the successful implementation of the proposed bed reductions. To achieve this, the original $800,000 in general funds reduced from Southside's budget needs to be restored as an amendment to the Appropriation Act. Also, the Department proposes that the bed reduction momentum be maintained by funding Clozaril and other similar medications that will enable discharge for treatment resistent patients.

APPENDIX B

Virginia Association of Community Services Boards, Inc.

FY-94 Consumer/Service & Cost Data

VIRGINIA ASSOCIATION OF COMMUNITY SERVICES BOARDS, INC.

05-Jan-95

FY-94 CONSUMER/SERVICE & COST DATA

*Note: Represents 38 of 40 CSBs; Data subject to verification

		MENTAL HEALTH					MENTAL RETARDATION					SUBSTANCE ABUSE					MH/MR/SA				
	Unit of Service	Consumers	Units	Costs	Avg.Cost/ Consumer	Avg. Unit Cost	Consumers	Units	Costs	Avg.Cost/ Consumer	Avg. Unit Cost	Consumers	Units	Costs	Avg.Cost/ Consumer	Avg. Unit Cost	Consumers	Units	Costs	Avg.Cost/ Consumer	Avg. Unit Cost
EMERGENCY	Hours	47,362	306,016	$13,156,117	$278	$43	117	6,767	$221,257	$1,891	$33	11,687	57,212	$2,654,456	$227	$46	59,166	369,995	$16,031,830	$271	$43
INPATIENT	Bed Days	1,421	8,440	$1,945,278	$1,369	$230						116	1,148	$218,941	$1,887	$191	1,537	9,588	$2,164,219	$1,408	$226
Community Hospital Based Detox	Bed Days											201	942	$248,928	$1,238	$264	201	942	$248,928	$1,238	$264
Total		1,421	8,440	$1,945,278	$1,369	$230						317	2,090	$467,869	$1,476	$224	1,738	10,530	$2,413,147	$1,388	$229
OUTPATIENT/CASE MANAGEMENT																					
Outpatient	Hours	65,010	877,112	$40,541,191	$624	$46	472	13,631	$531,240	$1,126	$39	37,363	576,101	$25,357,480	$679	$44	102,845	1,466,844	$66,429,911	$646	$45
Intensive In-Home	Hours	807	104,443	$4,400,915	$5,453	$42											807	104,443	$4,400,915	$5,453	$42
Case Management	Hours	35,946	$14,299	$20,342,183	$566	$40	11,862	267,292	$10,390,200	$876	$39	16,083	126,807	$5,431,248	$338	$42	63,891	910,398	$36,163,631	$566	$40
Methadone Detox	Hours											90	12,161	$78,308	$870	$6	90	12,161	$78,308	$870	$6
Methadone Maintenance	Hours											1,564	67,425	$2,413,839	$1,543	$36	1,564	67,425	$2,413,839	$1,543	$36
Total		101,763	1,496,854	$65,284,289	$642	$44	12,334	280,923	$10,921,440	$885	$39	55,100	784,494	$33,280,875	$604	$42	169,197	2,561,271	$109,488,604	$647	$43
DAY SUPPORT																					
Day Treatment/Partial Hosp	Day Hours	642	84,605	$1,744,126	$2,717	$21						2,258	332,493	$3,684,961	$1,632	$11	2,900	417,298	$5,429,087	$1,872	$13
Therapeutic Day Treatment C&A	Day Hours	235	79,174	$1,298,687	$5,526	$16						71	4,998	$26,401	$372	$5	306	84,172	$1,325,088	$4,330	$16
Psychosocial Rehab	Day Hours	5,092	1,948,566	$15,293,495	$3,003	$8											5,092	1,948,566	$15,293,495	$3,003	$8
Day Health & Rehab/Develop. Day	Day Hours						1,246	1,099,425	$10,188,039	$8,177	$9						1,246	1,099,425	$10,188,039	$8,177	$9
Total		5,969	2,112,545	$18,336,308	$3,072	$9	1,246	1,099,425	$10,188,039	$8,177	$9	2,329	337,491	$3,711,362	$1,594	$11	9,544	3,549,461	$32,235,709	$3,378	$9
Sheltered Employment	Days	84	5,487	$386,181	$6,034	$70	2,399	398,382	$14,715,586	$6,134	$37						2,483	403,869	$15,101,767	$6,131	$37
Supported Employment Group	Days	47	5,973	$162,745	$3,463	$27	544	85,021	$5,295,520	$9,734	$62						591	91,994	$5,458,265	$9,236	$59
Total		111	11,460	$548,926	$4,945	$48	2,943	484,403	$20,011,106	$6,800	$41						3,054	495,863	$20,560,032	$6,732	$41
Education/Recreation	Hours	121	3,252	$74,533	$616	$23	1,682	41,675	$525,024	$312	$13						1,803	45,127	$599,557	$333	$13
Supported Employment	Hours	476	20,765	$769,352	$1,616	$37	1,646	146,730	$4,998,046	$3,036	$34						2,122	167,495	$5,767,398	$2,718	$34
Alternative Day Support	Hours	41	33,252	$133,757	$3,262	$4	237	54,948		$0	$0						278	88,196	$133,757	$481	$2
Total		638	57,269	$977,642	$1,532	$17	3,585	243,551	$5,523,070	$1,549	$23						4,203	300,820	$6,500,712	$1,547	$22
RESIDENTIAL																					
Primary Care	Bed Days											3,508	58,464	$3,716,100	$1,059	$64	3,508	58,464	$3,716,100	$1,059	$64
Intermediate Rehabilitation	Bed Days											670	29,827	$3,126,262	$4,669	$105	670	29,827	$3,126,262	$4,669	$105
Long Term Habilitation	Bed Days											933	97,223	$5,899,182	$6,323	$61	933	97,223	$5,899,182	$6,323	$61
Group Homes	Bed Days	338	57,196	$5,926,264	$17,533	$104	715	217,758	$23,394,951	$32,720	$107	258	16,547	$789,016	$2,981	$46	1,311	291,501	$30,090,231	$22,952	$103
Supervised Apartments	Bed Days	586	117,742	$5,005,679	$8,542	$43	382	117,012	$5,861,574	$15,344	$50	149	18,102	$620,573	$4,165	$34	1,117	252,856	$11,487,826	$10,285	$45
Domiciliary Care	Bed Days	26	6,782	$487,889	$18,765	$72	93	31,265	$1,955,533	$21,027	$63						119	38,047	$2,443,422	$20,533	$64
Sponsored Placements	Bed Days	518	106,893	$2,090,945	$4,037	$20	123	35,225	$1,044,015	$8,488	$30	4	111	$510	$128	$5	645	142,229	$3,135,470	$4,861	$22
Treatment Center/ICF/MR/Social Detox	Bed Days	544	16,235	$3,238,111	$5,952	$199	132	41,153	$7,042,608	$53,353	$171	7,454	51,309	$5,833,062	$783	$114	8,130	108,697	$16,113,781	$1,982	$148
Emergency Shelter/Residential Respite	Bed Days	2,068	11,600	$1,607,809	$777	$139	177	2,448	$299,673	$1,693	$122	9	131	$1,290	$143	$10	2,254	14,182	$1,908,772	$847	$135
Total		4,080	316,451	$18,356,697	$4,499	$58	1,622	444,861	$39,596,354	$24,413	$89	12,985	271,714	$19,967,995	$1,538	$73	18,687	1,033,026	$77,923,048	$4,170	$75
In-Home Respite	Hours	301	22,475	$163,186	$542	$7	760	95,022	$930,444	$1,224	$10						1,061	117,497	$1,093,630	$1,031	$9
Supported Living Arrangements	Hours	3,104	104,387	$4,374,104	$1,409	$42	886	254,991	$4,473,073	$5,049	$18	799	10,608	$460,396	$576	$43	4,789	369,986	$9,307,573	$1,944	$25
Family Support							1,033	11,931	$819,456	$793	$69						1,033	11,931	$819,456	$793	$69
Total		3,405	126,862	$4,537,290	$1,333	$36	2,679	361,944	$6,222,973	$2,323	$17	799	10,608	$460,396	$576	$43	6,883	499,414	$11,220,659	$1,630	$22
PREVENTION/EARLY INTERVENTION																					
Prevention	Hours		59,297	$2,185,245		$37		12,714			$0		242,312	$8,454,661		$35	N/A	314,323	$10,639,906	N/A	$34
Early Intervention	Hours	2,843	29,448	$1,174,967	$445	$41	4,466	228,428	$8,627,442	$1,932	$38	4,921	48,959	$1,957,800	$398	$42	12,030	303,835	$11,760,209	$978	$39
TOTALS	Unduplicated Estimate	105,369		$126,502,758			18,990		$101,313,681			56,548		$70,955,414			180,927		$298,771,854	$1,651	

APPENDIX C

Funding Local Mental Health, Mental Retardation, and Substance Abuse Services

FUNDING LOCAL MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE SERVICES

Introduction

The Department of Mental Health, Mental Retardation and Substance Abuse Services supports a variety of local community services. This support began during the 1940s with the establishment of state-run local mental hygiene outpatient clinics. The Department developed a network of these clinics across Virginia during the 1950s and 1960s, eventually operating 38 mental health clinics. These clinics had local advisory boards, which were the precursors of many of the Community Services Boards (CSBs). However, other community mental health services were not available. Also, publicly-financed mental retardation and substance abuse services did not exist, except for some outpatient alcoholism clinics operated by the Virginia Department of Health.

The history of state financial support for a broader range of local services really began in 1968 with the addition of Chapter 10 to Title 37.1 of the Code of Virginia. This legislation allowed cities and counties, singly or jointly, to establish local mental health and mental retardation services boards. That statute enabled the Department to fund previously unavailable local mental health and mental retardation services through these locally-established Community Services Boards.

Initially, Prince William County and Arlington County established CSBs in 1968. Local governments, with assistance from the Department, created thirteen boards the next year and another one in 1970. The General Assembly passed the first CSB appropriation in 1970. In Fiscal Year 1971, the Department distributed $480,078 of State General Funds to 14 CSBs. The next year, $1,273,177 were distributed, a 165 percent increase.

The system has grown dramatically in the intervening years. Now, CSBs receive Federal Block Grant funds as well as State General Fund appropriations through the Department. Today, all 136 jurisdictions participate in a Community Services Board. These CSBs provide vitally-needed services to tens of thousands of Virginians through hundreds of directly operated and contractual programs. In FY 1994, 188,353 individuals received mental health, mental retardation or substance abuse services through CSBs.

How Are Community Services Funded?

From passage of the original enabling legislation by the General Assembly in 1968 to the present, the Commonwealth, through the Department, has always funded community services boards through a ***matching grant*** mechanism, in which certain local funds, local government appropriations, charitable contributions, and specific types of in-kind donations, match State General funds. This reflects the historic partnership that has characterized the state's approach to community mental health, mental retardation, and substance abuse services.

Matching Grants

The original legislation established a 50:50 ratio of state to local matching funds. During the first six years of state support for CSBs, localities actually provided more than half of the money. This level of support reflects the successful efforts of legions of volunteers, who advocated with their cities and counties to establish and fund CSBs. It also reflects the historical pattern of CSB development; that is, most of the initial boards were developed in urban areas, particularly in Northern Virginia, Tidewater, and the Richmond area, which tend to have more resources.

In Fiscal Year 1977, the balance shifted as the state began to appropriate substantially larger amounts for community services. In that year, the state to local ratio of matching funds was 51:49. This change was reflected in amendments to the statute that lowered the local minimum share, first to 25 percent and finally to 10 percent. While a number of CSBs, mostly in rural areas with fewer resources, receive only the minimum local match from their jurisdictions, most urban and more affluent areas provide much more than that minimum 10 percent local match.

Local Government Matching Funds

Tables 1 and 2 portray patterns of local government support. Health Planning Region (HPR) 1 covers northwestern Virginia: Winchester, Staunton, Charlottesville, Culpeper, and Fredericksburg. HPR 2 covers northern Virginia. HPR 3 covers southwestern Virginia: from Danville, Lynchburg, Roanoke west. HPR 4 is central Virginia. HPR 5 covers Tidewater, the Peninsula, the Middle Peninsula and Northern Neck, and the Eastern Shore.

TABLE 1: PER CAPITA LOCAL GOVERNMENT MATCHING FUNDS BY REGION

Region	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995
HPR 1	2.58	2.58	2.56	2.58	2.60	2.66
HPR 2	33.74	40.46	39.54	39.06	40.38	43.05
HPR 3	2.03	2.19	2.25	2.31	2.26	2.34
HPR 4	10.16	11.52	11.63	12.05	12.46	13.36
HPR 5	6.57	7.14	7.21	7.19	7.34	7.52
STATE	11.97	13.93	14.01	13.97	14.46	15.39

TABLE 2: LOCAL GOVERNMENT MATCHING FUNDS BY REGION

Region	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995
HPR 1	2,125,600	2,131,980	2,141,236	2,154,148	2,237,128	2,329,921
HPR 2	48,218,838	57,817,643	57,982,318	57,278,648	60,684,402	66,249,790
HPR 3	2,583,595	2,785,707	2,798,428	2,869,905	2,852,044	2,944,312
HPR 4	10,979,353	12,451,993	12,357,211	12,801,761	13,463,550	14,696,314
HPR 5	10,675,254	11,589,143	11,378,676	11,348,461	11,697,200	12,184,111
STATE	74,582,640	86,776,466	86,657,869	86,452,923	90,934,324	98,404,448

Sources: 1. Local government matching funds come from Exhibit D of the CSB Performance Contracts.
2. Population figures used to calculate per capita figures are from the University of Virginia Center for Public Service and reflect U.S. census figures or final population estimates that are confirmed by local governments.

Because the state has always funded community services through a matching grant mechanism, proportionately more of the available State General Funds appropriated for this activity flowed to those areas, predominantly urban and affluent, that were able to provide the necessary match. Thus parts of central, eastern, and northern Virginia captured most of the state funds during the early stages of the Community Services Board system's development. In fact, recognition of other localities' difficulties in meeting the higher match ratio requirement led to amending the law to lower that requirement so that the Department could distribute its funds more widely to meet service needs over a broader geographic area.

The next table displays the aggregate or statewide ratios of State General to Local Matching funds since the state began granting funds for local services. Local Matching Funds include appropriated local government matching funds, which were displayed in Tables 1 and 2, plus some charitable contributions and certain in-kind match (space, equipment, professional staff volunteers).

TABLE 3: STATE AND LOCAL MATCHING FUNDS AND PERCENTAGES FOR MATCH RATIOS

Fiscal Year	State Funds	State Percentage	Local Matching Funds	Local Percentage	State & Local TOTAL
1973	2,150,747	45.11	2,616,611	54.89	4,767,358
1974	3,572,656	49.56	3,636,736	50.44	7,209,392
1975	7,381,442	48.44	7,857,127	51.56	15,238,569
1976	8,423,736	47.66	9,249,771	52.34	17,673,507
1977	11,860,939	51.48	11,178,329	48.52	23,039,268
1978	17,835,686	54.51	14,885,151	45.49	32,720,837
1979	24,370,512	58.02	17,636,677	41.98	42,007,189
1980	29,541,368	60.73	19,099,530	39.27	48,640,898
1981	34,922,193	61.59	21,778,931	38.41	56,701,124
1982	40,101,178	62.29	24,273,397	37.71	64,374,575
1983	46,380,346	61.99	28,443,187	38.01	74,823,533
1984	54,282,164	63.37	31,377,912	36.63	85,660,076
1985	61,466,377	63.31	35,614,397	36.69	97,080,774
1986	68,485,869	62.85	40,480,535	37.15	108,966,404
1987	77,371,977	62.06	47,307,276	37.94	124,679,253
1988	84,749,282	60.16	56,115,796	39.84	140,865,078
1989	110,512,740	62.62	65,976,642	37.38	176,489,382
1990	137,382,590	63.80	77,953,480	36.20	215,336,070
1991	124,315,794	58.72	87,375,944	41.28	211,691,738
1992	119,862,033	57.77	87,605,994	42.23	207,468,027
1993	121,995,034	58.10	87,975,355	41.90	209,970,389
1994	121,726,275	56.89	92,244,884	43.11	213,971,159
1995	118,132,188	54.04	100,473,085	45.96	218,605,273

NOTE: State Funds include only State General Funds; they do not include Medicaid State Plan Option or Mental Retardation Waiver match; this is reflected in Fee revenues.

Match ratios vary tremendously among CSBs. For instance, one CSB may barely meet the 10 percent minimum matching requirement, while another CSB may have a match ratio of 33:67, with ⅔ of the matching funds supplied by local governments. Also, match ratios vary among program areas (mental health, mental retardation, substance abuse, and administration) within a CSB. For example, the match ratio for a one area may be 100:0; that is, this area has no local match. Yet in another program area, the match ratio may be 25:75; that is, ¾ of the matching funds are supplied by local government(s).

Sources of Funds for Community Services

State General Funds

Along with the local matching funds just described, the core of the funding base for community services includes State General Funds. Unlike other revenue sources, such as client and third party fees, CSBs do not have to "earn" these core revenue sources. State and local government funds are granted to CSBs, based on political and policy decisions that their services deserve public support.

The Commonwealth has had a strong and continuous commitment to funding local mental health and mental retardation services since the inception of the CSB system. This commitment expanded to include substance abuse services when they became a Department responsibility in the late 1970s. The following table portrays the history of Virginia's policy commitment to serving individuals with serious mental disabilities and substance abuse problems.

TABLE 4: GROWTH OF STATE GENERAL FUNDS FOR CSBs

Fiscal Year	Amount	Percent Increase	Fiscal Year	Amount	Percent Increase
1971	480,078	---	1986	68,485,869	11.4
1972	1,273,177	165.2	1987	77,371,977	13.0
1973	2,150,747	68.9	1988	84,749,282	9.5
1974	3,572,656	66.1	1989	110,512,740	30.4
1975	7,381,442	106.6	1990	137,382,590	24.3
1976	8,423,736	14.1	1991	124,315,794	-9.5
1977	11,860,939	40.8	1992	119,862,033	-3.6
1978	17,835,686	50.4	1993	121,995,034	1.8
1979	24,370,512	36.6	1994	121,726,275	-0.2
1980	29,541,368	21.2	1995	118,132,188	-2.9
1981	34,922,193	18.2	*Please see the first paragraph on the next page for an explanation of the apparent decreases that begin in Fiscal Year 1991.*		
1982	40,101,178	14.8			
1983	46,380,346	15.7			
1984	54,282,164	17.0			
1985	61,466,377	13.2			

In the preceding table, the large increases in FY 1989 and FY 1990 reflect the Community Services Initiative, enacted by the 1988 General Assembly. The apparent decreases in funds beginning in FY 1991 reflect the successful implementation of the Medicaid State Plan Option (SPO) initiative, which uses State funds as match for the Federal Financial Participation (the federal share of Medicaid SPO fees). Apparent decreases would have been larger, but they were offset by additional appropriations for pay raises and for some focused service initiatives. Thus, while the amounts identified as State General Funds have declined slightly, the dramatic growth in Medicaid SPO fees has actually significantly increased the net revenues available for services.

Other Revenue Sources

State and Local Matching funds continue to constitute the majority of resources that finance community mental health, mental retardation, and substance abuse services. However, several other funding sources are crucial to supporting those services. Federal grants, primarily Federal Mental Health and Alcohol and Drug Abuse Block Grants, play an important role in funding local services. The most notable change in other revenues recently has been the extraordinary growth of fees, a 263 percent increase since FY 1990. This is attributable almost completely to the substantial expansion of Medicaid coverage through two initiatives: the State Plan Option (SPO) and the Mental Retardation Home and Community-Based Waiver. SPO allows CSBs to bill Medicaid for a range of previously uncovered case management and rehabilitative services. These include:

- **Mental Health Services:**
  - targeted case management,
  - crisis intervention,
  - intensive in-home services for children and adolescents with serious emotional disturbance and children at risk of serious emotional disturbance,
  - day treatment for adults with serious mental illness,
  - therapeutic day treatment for children and adolescents, and
  - psychosocial rehabilitation for adults with mental illness; and

- **Mental Retardation Services:**
  - targeted case management and
  - day health and rehabilitation services.

CSBs billed $ 50.5 million of SPO services in FY 1995, up from $ 41.6 million in FY 1994. This revenue source has grown tremendously since the SPO initiative started five years ago.

The Mental Retardation Waiver uses Medicaid funds to provide community services for individuals who have resided in or are at risk of admission to state-operated training centers. CSBs billed $ 31.2 million of Waiver services in FY 1995, up from $ 14.7 million in FY 1994.

The table on the next page displays the substantial growth in all revenue sources over the history of Community Services Boards. This demonstrates the strong state and local government and public support that CSB services have experienced and continue to enjoy.

TABLE 5: GROWTH OF ALL REVENUE SOURCES FOR CSBs

Fiscal Year	State Funds	Local Match	Fees	Federal Grants	Other	TOTAL REVENUES
1973	2,150,747	2,616,611	590,692	605,521	*	5,963,571
1974	3,572,656	3,636,736	1,492,246	602,458	*	9,304,096
1975	7,381,442	7,857,127	3,524,487	1,813,179	*	20,576,235
1976	8,423,736	9,249,771	5,832,458	2,091,996	*	25,597,961
1977	11,860,939	11,178,329	7,609,852	2,989,350	*	33,638,470
1978	17,835,686	14,885,151	9,625,344	3,720,402	*	46,066,583
1979	24,370,512	17,636,677	11,555,136	6,645,362	*	60,207,687
1980	29,541,368	19,099,530	11,040,172	6,629,259	3,262,590	69,572,919
1981	34,922,193	21,778,931	12,973,679	9,062,930	3,982,561	82,720,294
1982	40,101,178	24,273,397	13,624,002	9,438,837	4,262,255	91,699,669
1983	46,380,346	28,443,187	16,132,880	8,174,779	4,523,247	103,654,439
1984	54,282,164	31,377,912	18,113,009	10,214,649	5,460,798	119,448,532
1985	61,466,377	35,614,397	20,945,583	8,996,903	6,153,443	133,176,703
1986	68,485,869	40,480,535	21,804,665	10,151,083	6,563,860	147,486,012
1987	77,371,977	47,307,276	22,535,434	9,215,059	7,771,978	164,201,724
1988	84,749,282	56,115,796	25,339,197	10,551,149	9,602,233	186,357,657
1989	110,512,740	65,976,642	29,422,843	11,404,899	11,153,292	228,470,416
1990	137,382,590	77,953,480	29,826,356	16,754,811	10,871,864	272,789,101
1991	124,315,794	87,375,944	49,310,157	22,409,240	12,538,762	295,949,897
1992	119,862,033	87,605,994	68,283,297	26,607,865	11,622,171	313,981,360
1993	121,995,034	87,975,355	76,217,155	26,433,657	11,292,469	323,913,670
1994	121,726,275	92,244,884	89,124,523	29,125,552	11,482,567	343,703,801
1995	118,132,188	100,473,085	108,374,408	34,593,617	11,034,917	372,608,215

NOTES: 1. State Funds include only State General Funds; they do not include Medicaid State Plan Option or Mental Retardation Waiver match, which is reflected as part of those Medicaid revenues in the Fee column beginning in FY 1991.

2. * Other Revenues (Workshop sales, interest, other miscellaneous revenues) revenues were counted as Fees during FY 1973-1979.

3. Fees include: Medicaid, Medicare, Blue Cross, CHAMPUS, Direct Client Fees, Other Insurance, DRS Client Fees, Schools, and Commitments/Courts.

The preceding tables illustrate the growth and expansion of the CSB system. Data in the tables are based on Statements of Grant and Letters of Notification issued by the Department and on Performance Contracts negotiated by the Department with CSBs. These tables document the long history of the Commonwealth's continued and growing commitment to supporting local mental health, mental retardation and substance abuse services in all of Virginia's communities.

How Are State-Controlled Funds Allocated to Communities?

Background

The Commonwealth has always provided funds for community services through a matching grant mechanism, in which certain local funds (local government appropriations, charitable contributions, and specific types of in-kind donations) match State General funds. Chapter 10 of Title 37.1 of the Code, which authorizes the Department to make matching grants to cities and counties, requires local governments to establish Community Services Boards to become eligible for grant funds. Until 1980, this statute was permissive; a local government did not have to create a CSB unless it wanted to receive matching grants for community mental health, mental retardation, and substance abuse services. In that year, § 37.1-194 of the Code of Virginia was amended to require all cities and counties to establish or join a CSB by July 1, 1983.

By 1975, almost all Virginia cities and counties had created or joined one of the 36 established Community Services Boards. The last four CSBs were established in 1981 and 1982 to cover the remaining 10 jurisdictions. Most CSBs did not become operational until several years after they were formally established by their local governments. Staff needed to be hired, grants written, and the state-operated mental health clinic transferred to local control. Thus, although a CSB may have been created through local ordinances or resolutions passed by the city councils and boards of supervisors, it may not have received any funds for one or two years afterward.

Normally, when a CSB first sought state funds from the Department, it submitted an administrative staffing grant and perhaps a small program development grant. Over the next several years, it would seek additional funds, if it could produce the required matching funds. Eventually, the CSB developed the necessary administrative infrastructure, such as personnel and financial management policies and procedures, to transfer the state-operated mental health clinic to its control. Some urban clinics had large budgets and the transfer significantly increased the CSB's total budget and thus its funding base for future years.

From time to time, the General Assembly has appropriated additional funds earmarked for particular purposes, such as expanding residential services. In the earlier years of the system's development, these funds were often allocated based on the judgement of Department staff. Again, because of the voluntary nature of the system and the requirement for local match, more of these state funds were allocated to urban, more affluent areas and areas with particularly great needs.

In describing the funding of community services, this paper distinguishes between how funds are allocated to CSBs and how funding is actually approved and administered. The first activity only establishes the amounts of state and federal block grant funds each CSB is eligible to receive. The second activity involves the Department's review and approval of each CSB's specific proposals for how it will use those allocations.

Statutory Allocation Criteria

Section 37.1-199, paragraphs (b) and (c), of the Code of Virginia stipulates the factors that the Department shall consider in allocating state funds for community services. These factors include:

1. the total amount of funds appropriated to the Department for this purpose,
2. the total amount of funds requested by the local CSB,
3. the financial abilities of all of the local governments participating in the board to provide funds required to generate the requested state match,
4 the type and extent of programs and services offered or planned by the local CSB,
5. the availability of services provided by the local CSB in the areas served by it, and
6. the ability of the services provided by the local CSB to decrease financial costs to the Department and increase the effectiveness of treatment by reducing state facility admissions.

The Appropriations Act also contains factors that the Department must consider. For example, the Act requires CSBs to participate in the Medicaid State Plan Option initiative or not be eligible for funds. It also prohibits using additional state appropriations to replace local matching funds.

Historical Allocation Method: Incremental Continuation of Base Funding

Traditionally, the Department has allocated State General and Federal Block Grant funds to each Community Services Board (CSB) based on the amounts of those funds appropriated by the General Assembly. Often, those appropriations have included funds for the state share of a pay raise. Frequently, particularly during the early developmental period in the CSB system's history, appropriations would also include earmarked funds for special program initiatives.

Thus, given the legislative intent and actions, the primary basis of allocation historically has been and still is continuation of the base level of funding, increased by the amount of any pay raise. Special initiatives were sometimes designated for particular areas or CSBs; at other times, these earmarked additional funds were intended for broader, general distribution. These decisions have affected the relative proportions of state funding that each CSB has received. Over the years, these patterns have varied, but a persistent characteristic has generally been that older, larger, or more affluent CSBs have tended to continue to receive larger amounts of resources. As the 1980 Commission on Mental Health and Mental Retardation noted, historically, the growth and development of the CSB system was based on local initiative and local ability to match or draw down state funds to provide community services in accordance with state and local priorities. Because local initiative and support have varied considerably across the state, the distribution of state dollars has not been considered to be mathematically equitable.

Although the issue of funding equity has long been of great interest to many CSBs, large and small, urban and rural, the issue is complex. For example, although many urban CSBs have larger amounts of state funds, their *per capita state funding levels* are much lower than smaller, rural, less populous CSBs. Conversely, the *total per capita funding levels* (including all revenue sources) of those same urban CSBs are much higher than the smaller, rural CSBs, due in large part to the much greater amounts of local match that those urban CSBs receive.

The Funding Formula - 1983

The Commission on Mental Health and Mental Retardation directed the Department to identify basic or core services and to develop a funding formula for distribution of state funds that would improve funding equity and improve statewide accessibility of core services. The Commission had examined the facility and community service delivery system in the late 1970s and found numerous

areas of the Commonwealth without access to basic services, while other localities had developed more adequate networks of services. The Commission also identified large variations among CSBs in the level of state funding support that they received.

The Department assembled the Task Force on Core Services, Formula Funding, and Facility Census Reduction, a very large group with over 60 members representing CSBs, state facilities, advocacy and constituency groups including family members of patients and residents in state facilities, and Department staff. The Task Force was charged, among other responsibilities, with recommending a funding formula. The Task Force spent much of 1982 reviewing the entire range of possible funding formula factors. Modelling and careful analysis of more than 40 factors did not identify acceptable elements.

The Department presented the Final Report of the Task Force to the Governor and General Assembly on October 1, 1983. Major difficulties were identified in the implementation of any formula, even if the elements or factors were agreed upon. These included such issues as whether the formula called for redistribution of existing state-controlled resources that could cause chaos in the existing community service delivery system. Likewise, a formula that was seen as penalizing local CSBs and governments for their past support of these community programs was seen as counterproductive. Also, a purely population-driven mathematical formula could impede efforts to address gaps in core services. The report indicated that the Department was not aware of any states that had implemented a formula that was purely mathematical or that redistributed existing resources. The Report listed the major limitations of a purely mathematical funding formula.

- Mathematical formulas often attempt to achieve equity among disparate entities. In the CSB service delivery system at that time, this would have involved redistributing significant amounts of state-controlled dollars, thus disrupting or eliminating many existing and needed core services.

- An arithmetic formula, by itself, usually does not address performance, efficiency, or incentives for altering service delivery patterns and improving use of available state funding.

- The review of other states revealed significant problems with developing and implementing mathematical formulas. Other areas of Virginia's State government had also encountered significant problems in this area.

In the Final Report, the Department recommended that Virginia not adopt a mathematical funding formula, based on the fact that a formula by itself does not:

- reflect program or service needs or

- allow targeting of state-controlled resources to:

  - reduce state facility census (a priority of the Commission),
  - fill gaps in core services (another priority of the Commission),
  - serve special populations (e.g., children, older adults, forensic patients, and persons with dual diagnoses), and
  - address performance in terms of effectiveness and cost.

In lieu of implementing a funding formula, the Department proposed, and the General Assembly accepted, continuing to fill gaps in core services and use joint CSB-state facility planning and performance contracting mechanisms to reward successful performance and to meet documented service needs. The overwhelming proportion of state-controlled funds, State General and Federal Block Grant funds, continued to be allocated using the historical allocation method: incremental continuation of base funding.

The Funding Formula Allocation System - 1986

Despite the conclusions of the Final Report of the Task Force on Core Services, Formula Funding, and Facility Census Reduction, the Department established another task force, the Community Services Board Funding Allocation Task Force, in 1986 to develop an allocation system for state-controlled funds that would distribute monies to CSBs in a methodologically defensible manner and move the system towards greater equity. This task force was much smaller than the previous group; it contained eight representatives from CSBs and nine Department staff members.

The group met four times in the fall and winter of 1986. It reviewed formulas used by the Departments of Social Services and Aging, funding criteria used by the 50 states for community mental health services, and more detailed information about several of those states. The group adopted the following *conceptual framework* to guide the development of an allocation system.

CONCEPTUAL FRAMEWORK

General Concept:

- The allocation mechanism or system sets a **target funding level** for the CSB. Actual funding may depend on performance.

- The goal is to achieve **fiscal rather than service equity**. It is not intended to address establishment of a minimum floor of core services in each CSB.

- The mechanism or system must:

  - use **generally accepted** measures,
  - use **standard** indexes and statistics,
  - be as **simple** as possible,
  - reflect **relative need** for services,
  - be professionally defensible, and
  - be politically sellable.

- There should be **separate mechanisms** for each program area (mental health, mental retardation, and substance abuse), based on need indicators.

Implementation:

- The system or mechanism should be phased in gradually, perhaps over a ten-year period.

- The system should be consistent with the planning process.

- Separate mechanisms or systems **should not** be developed for different core services.

- The allocation system should **maintain current funding levels**; state-controlled funds should be held harmless. This includes maintenance increases above the previous year's absolute dollar allocations.

- The system **should not** build in financial incentives for CSB service consolidations and regional programs.

Funding Sources:

- The allocation mechanism should **only** apply to **state-controlled funds**. This would **not** include state balances.

- The system **should not** include local matching funds or fee revenues.

- The system **might** include the costs of **state facility services** to residents and patients from the CSB's catchment area (**NOTE**: *the actual formulas never have included this factor*).

- The system **should not** allocate **administrative funding**. Administrative costs should be identified in a cost center and allocated across services.

- The system should only actually allocate **new state-controlled funds**, available above maintenance obligations and other earmarked, categorical, or specialized appropriations.

Factors/Criteria:

- Separate formulas **should not** be developed for specific priority services and/or populations. They could be dealt with through the plan and the performance contracting process and during negotiations on the use of the funds allocated through the system.

- The availability of private sector resources within a CSB area **should not** be incorporated in the allocation mechanism or system.

- The system should have a heavy **per capita/population emphasis**. **Poverty** and **relative ability** (of localities) **to pay** should also be factored into the system.

- **Need indicators** should be considered **separately** for each program area (mental health, mental retardation, and substance abuse).

The Task Force considered various criteria, weights, and factors and selected the following social or need indicators for each program area.

Mental Health:

- poverty rate
- percent of minority population
- percent of unemployment

Mental Retardation:

- poverty rate
- percent of births to women over 35 (five year average)
- percent of teen births (five year average)
- percent of special education students (only MR/multi-handicapped)

Substance Abuse:

- poverty rate
- substance abuse deaths (five year average)
- percent unemployment

Other indicators were considered and rejected as not readily available or generally acceptable.

The Task Force also made the following recommendations:

- no set-asides for special populations (these should be addressed through the planning process),
- exclude state facility usage and costs for now, and
- spread administrative support costs across services in the 1990-1992 biennium, also deal with administrative needs through the planning process.

The Task Force considered ability to pay and recommended basing this factor on the true value of real property (weighted two-thirds) and personal income (weighted one-third). The weights were chosen because real property is a clearer indicator of the potential local match since it is tied more closely to the local tax base.

The Task Force proposed a funding formula as the centerpiece of the CSB allocation system. The primary characteristics of the ***funding formula*** are:

- a **separate formula** for each program area, based on each CSB's population, adjusted upward or downward for weighted need indicators and an ability to pay factor; and

- the formula generates a **target funding level** for each CSB, expressed as a percent of the total adjusted population.

The primary characteristics of the ***allocation process*** for each program area are:

- current funding levels are **held harmless** and maintained for inflation and cost of living increases;

- the **target funding level** or percentage is compared to the current funding percentage for each CSB to determine its **equity variance**;

- a portion of any new (above maintenance) state-controlled funds is allocated to all CSBs using the **target funding percentages**, this establishes revised current funding levels and new equity variances;

- a portion of new funds is allocated to Boards to **correct equity variances**, the greater the variance, the greater (proportionately) the amount of this allocation; and

- the addition of these last allocations establishes **revised funding** levels for future equity comparisons.

Thus, the net effect of the formulas and the allocation process is to reduce the variances in equitable funding levels, as defined by the formulas, among the CSBs for each program area. This proposal was accepted by the Virginia Association of Community Services Boards at its January, 1987 meeting. The Department used this funding formula allocation system to distribute the significant state fund increases appropriated through the 1988-1990 Community Services Initiative. However, the Department still allocates the overwhelming proportion of state-controlled funds (State General and Federal Block Grant funds), which is appropriated by the General Assembly for maintaining the current levels of services, using the historical allocation method: incremental continuation of base funding.

Funding Allocation System - 1988

The Department reconvened the Community Services Board Funding Allocation Task Force in 1988 to review and consider any changes in the funding allocation system. The group reaffirmed its support of the original Conceptual Framework and added two new Implementation provisions.

- Funds allocated through this mechanism cannot be used to replace or supplant local matching funds. (This reiterates the Appropriations Act prohibition against using new state funds to replace or supplant local matching funds.)

- The Department should use this allocation mechanism to distribute any new state-controlled revenues that are not specifically earmarked or reserved for pilot or demonstration projects or for special populations.

The Task Force also reviewed the transitional distribution system, the implementation of the allocation system with a portion of the new funds used to move CSBs closer to their target or equity funding levels. At that time, 20 percent of new funds were earmarked for this purpose. The Task Force considered the relatively small progress made toward equity in the first round of 1988-1990 Community Services Initiative allocations and recommended that the percentage of new funds used to reduce the funding variance among CSBs be raised to 50 percent. This would increase the rate at which the equity gap would be closed. Those suggested changes were adopted.

The response to this formula-driven, population-based CSB funding allocation system has been very positive from the General Assembly, CSBs, and constituency groups. Perhaps the most convincing evidence of its support among CSBs is their frequent request that this system be used to allocate funds for special initiatives and projects. Generally, the Department has used the system when the amount of any new appropriation has been sufficiently large to ensure that even the smallest CSB will receive an amount that is large enough to be used reasonably. For instance, if the new appropriation for a special project was $250,000, the Department would not use the funding allocation system because the amounts received by small CSBs would be too small to effect a meaningful impact.

However, despite broad acceptance and support, several concerns have been raised periodically about the funding formula allocation system.

- One common criticism is the system's failure to account for the cost of providing services in rural versus urban areas. Urban CSBs express a concern that the system does not reflect their higher cost of living and doing business. However, rural CSBs note that their higher costs of providing services in sparsely populated very large areas, with the attendant greater transportation costs and large amounts of staff time spent traveling, are not addressed.

- Another criticism is that some CSBs may have a systematically greater percentage of the state's population in need of services than is indicated by the funding formulas.

- A third concern is that the formula-driven funding allocation system does not account for the differences in local government matching funds that various CSBs receive. The disparity in the amounts of local funds received between large urban CSBs and rural CSBs is dramatic and it continues to widen. Tables 1 and 2 display this disparity graphically.

In conclusion, state-controlled funds are allocated among CSBs based on two methodologies. The first method, the historical incremental continuation of base funding, still affects the major portion of state-controlled resources. This reflects the legislature's intent to maintain the current levels of services as a first priority, particularly when resources are scarce. The second method, the formula-driven funding allocation system, affects a much smaller share of state-controlled resources.

How Are State-Controlled Funds for Community Services Administered?

Program Application

In the early years of the system's development, CSBs submitted Program (grant) Applications, detailed line item budgets that listed specific personnel position expenditures and particular operating costs, to receive grants of state funds. These Program Applications contained no information about clients or consumers and services. In the late 1970s, very basic client and service information was added to the application format.

Each CSB's Program Application was reviewed and approved by Department program and fiscal staff and became the basis on which the CSB was granted State General Funds, and later Federal Block Grant funds. Analysis and decisions about approving these applications centered around the reasonableness of costs and the feasibility of new program proposals. No standard review criteria existed for decision making, which was based on the staff's best professional judgement. The Department continued to use the Program Application as the basic funding document until it was replaced, on a phase-out basis, by the Performance Contract in 1985. Use of the Application ended completely in FY 1988.

Community Services Board Performance Contract

One of the recommendations of the Final Report of the Task Force on Core Services, Formula Funding, and Facility Census Reduction was to base state funding allocations, in part, on performance contracts negotiated between the Department and individual Community Services Boards. The Report noted that this would shift greater responsibility for client services to the community, while enabling the Department to set statewide service priorities, target the use of state funds, monitor the operations of CSBs and their programs, and improve accountability for state funds.

The Department implemented performance contracting with CSBs for Fiscal Year 1985. Initial efforts were very basic, as the Department and the CSBs worked collaboratively to develop more useful and measurable definitions of services and consumers and refined the Core Services Taxonomy, the basic classification of services, units, and consumers used to describe, measure, and report on the services system's activities. Because of the evolutionary nature of the contract mechanism's development and the related data requirements that many CSBs could not satisfy initially, the Department continued using the Program Application in parallel with the Performance Contract for several years.

As CSBs improved their management information capabilities and adapted their organizational and clinical processes to the Performance Contract, the Department began certifying individual CSBs as they were ready to switch to sole use of the contract, thus eliminating the very detailed and relatively less useful Program Application. By Fiscal Year 1988, the Department discontinued use of the Application for all CSBs. This transition reflected a major shift in the way in which the Department relates to CSBs. The Department moved from an exclusively fiscal definition of accountability to one that encompassed service and consumer accountability and de-emphasized reliance on detailed budgeting and fiscal reporting.

The current CSB Performance Contract and its related Reports enable the Department to gather and analyze an extensive amount of information about the characteristics of the populations served by CSBs; the types, quantities, and costs of services delivered; and the sources of revenues used to support those services. The Performance Contract has attained many of the goals established for this mechanism in the 1983 Final Report on Core Services and Formula Funding.

APPENDIX D

Principles to Guide and Operational Concepts for Virginia's Publicly-Funded Mental Health, Mental Retardation and Substance Abuse Services System

Principles to Guide

and

Operational Concepts

for

Virginia's Publicly-Funded

Mental Health, Mental Retardation and Substance Abuse

Services System

September 25, 1995

Principles to Guide and Operational Concepts for Virginia's Publicly-Funded Mental Health, Mental Retardation and Substance Abuse Services System

Executive Summary:

As the Commonwealth of Virginia considers how best to improve mental health, mental retardation, and substance abuse services to its citizens, decisions must be guided and managed by sound, agreed-upon principles integrating the best information and technologies available. The adherence to such principles is necessary in order to ensure the provision of quality MHMRSAS services to the target populations which historically have been served with public funding.

The status quo in the MHMRSAS system is no longer acceptable. Virginia can no longer afford to spend such a large proportion of its resources on the state facility system while providing such limited funds to the community-based system of services. Virginia must move to a fully integrated system of care which is locally based.

As the Commonwealth of Virginia approaches the redesign of its MHMRSAS system, it must be accompanied by a clear understanding of how the public interest will be served through change. The values and principles which are selected to guide the development and improvement of the publicly-funded MHMRSAS system are critically important to those citizens who will be served and the services to be rendered.

A coalition of organizations including the Virginia Association of Community Services Boards, Virginia Alliance for the Mentally Ill, Virginia Mental Health Association, and Virginia Mental Health Consumers Association have worked together to develop the following principles and concepts that should serve as the foundation for the future system of publicly-funded mental health, mental retardation, and substance abuse services in Virginia:

Guiding Principles:

1. Community-based planning and decision-making should drive the system.

2. The system should be consumer-centered.

3. MHMRSA services should be fully integrated and well coordinated with other community services.

4. A single, local organization should be responsible for the management and coordination of MHMRSA services.

5. Public funding for MHMRSA services should be fully integrated.

6. The MHMRSAS system should redirect and reinvest resources as necessary to address consumer need.

7. A network of public and private providers with sufficient expertise and capacity is essential.

8. The publicly-funded MHMRSAS system should be outcome oriented.

9. The system should contain cost.

10. Cost of services should not be shifted to local government.

Operational Concepts:

1. Community Services Boards should remain the single local organization responsible for the publicly-funded MHMRSA system.

2. All public funds that support the MHMRSA system should be integrated at the local level through the CSB.

3. Public MHMRSA funding should be allocated based on eligible populations.

4. Eligible populations should be defined.

5. CSBs should provide services through a network of CSB and private providers, including the purchase of services from state facilities.

6. MHMRSA services should be evaluated based on agreed-upon outcomes.

7. Standards regarding access to services should be established.

8. The CSBs should accept responsibility and risk for services to eligible populations.

9. The development of public/private partnerships should be continued.

10. The State should retain the responsibility for persons found not guilty by reason of insanity or incompetent to stand trial.

11. The MHMRSAS system should maximize Medicaid for persons with mental disabilities.

12. The MHMRSA system changes should be evaluated to determine effectiveness.

"PRINCIPLES"
To Guide the Publicly-Funded
Mental Health, Mental Retardation, and Substance Abuse Services System

Introduction:

As the Commonwealth of Virginia considers how best to improve mental health, mental retardation, and substance abuse services (**hereafter referred to as** MHMRSAS) to its citizens, decisions must be guided and managed by sound, agreed-upon principles integrating the best information and technologies available. The adherence to such principles is necessary in order to ensure the provision of quality MHMRSAS services to the target populations which historically have been served with public funding.

The status quo in the MHMRSAS system is no longer acceptable. Change is overdue. Virginia can no longer afford to spend such a large proportion of its resources on the state facility system while providing such limited funds to the community-based system of services. Virginia must move to a fully integrated system of care which is locally based. The Virginia public MHMRSAS system must move even closer to the people it serves by strengthening local decision-making and local community direction and moving away from geographically distant, centrally-controlled state facilities. Oversight by local citizens, which includes consumers,. families, and elected and appointed officials, must be maintained while utilizing the best aspects of managed care technology.

As the Commonwealth of Virginia approaches the redesign of its MHMRSAS system, it must be accompanied by a clear understanding of how the public interest will be served through change. The values and principles which are selected to guide the development and improvement of the publicly-funded MHMRSAS system are critically important to those citizens who will be served and the services to be rendered. System reform is a major public policy initiative that warrants thoughtful consideration and planning. The planning process should include a meaningful dialogue among all members of the Virginia MHMRSAS constituency before any final decisions are made.

The following principles should guide the publicly-funded system of services:

Principle 1: Community-based planning and decision-making should drive the system.

The continued development of the MHMRSAS system should be based on a collaborative and participatory planning and decision-making process, which is community focused, and takes place at the local level. The planning process should recognize the unique characteristics within each community, including the specific demographic characteristics of the eligible populations to be served. At the local level, community-specific needs assessments should identify the existing capacity of the MHMRSAS service delivery system

and unmet need. The process should focus on leveraging the strengths of the current system, including the services of public and private agencies, and eliminating gaps in services. At the state level, planning must address those issues common to all communities and identify standards for consistent service delivery, maximum service capacity, protection of consumer rights, and oversight throughout the state.

To meet the special needs of adults with serious mental illness, children and youth with serious emotional disturbance, persons with mental retardation, children with developmental disabilities, and persons with substance abuse problems, the planning process should focus on the provision of a broad range of services. Community planning and decision-making should include consumers, families, public providers, private providers, and local government, in order to ensure that the service delivery system design will meet individual needs as well as those of the community at large.

Principle 2: The system should be consumer-centered.

To ensure the effectiveness of the MHMRSAS system, services and service delivery should be based on a commitment to: a) maximizing the well being and potential of each consumer, and b) establishing a general partnership among consumers, families and providers. Advocacy on behalf of consumers should be engaged in by consumers, families and providers and should be understood as necessary to ensure quality of services and service delivery.

The partnership among consumers, families and providers should ensure that reliable feedback about the system's effectiveness is continuous and utilized for system improvements. All service and service delivery evaluation, including satisfaction outcomes, should be based on evaluation designs that are generated by the partnership. The results of all evaluations will be available to all members of the partnership.

The system will provide for effective grievance and appeal procedures. Services and service delivery should ensure consumer choice in providers and types of services. Innovative services, such as consumer-run and family educational services, will be part of the service system. Outreach to and the engagement of all eligible consumers in services should be fundamental to the service delivery system.

Principle 3: MHMRSA services should be fully integrated and well coordinated with other community services.

The comprehensive array of emergency, outpatient, case management, day support, residential, prevention, early intervention, and inpatient services should be fully integrated to assure effective coordination. (See attachment "A".) The integrated system will allow consumers to easily and quickly access the range of needed services which will involve a variety of public and private providers, working in partnership with consumers toward consistent goals.

Coordination of services with other human services and public safety agencies is absolutely essential in order to provide the full range of services needed by eligible populations. MHMRSAS organizations frequently play a key role in the communities' response to the needs of children who are involved in the child protective services and juvenile justice systems. Effective coordination of services among local human service agencies enables the blending of multiple public funding sources. This improves service response and avoids costly duplication of effort. Systems that will help to assure service integration and coordination should be developed such as the capturing of common information and establishment of a primary case manager for each consumer.

Principle 4: A single, local organization should be responsible for the management and coordination of MHMRSA services.

To ensure integration of services, effective planning and accountability, publicly funded MHMRSA services should be the responsibility of a single local organization. This organization should have the administrative capability to manage and provide the broad continuum of community-based services utilizing public and private providers. The single local organization should be accountable to local government and the Department of MHMRSA Services.

Principle 5: Public funding for MHMRSA services should be fully integrated.

The single local organization should manage all of the public MHMRSAS financial resources, including state funds, federal funds, local funds, and Medicaid. (See attachment "B".) It is neither practical nor efficient to separate Medicaid-funded services from those public MHMRSA services that are funded by other state, federal, and local resources. When these resources are segregated, the result is inefficiency and the creation of multiple administrative structures and service delivery systems. Separation of funding streams often means that as consumers gain or lose Medicaid eligibility, they must access different service systems, thereby destroying service continuity. Integrating all public funding into a single stream at the community level maximizes flexibility in service delivery and provides the greatest opportunity for cost effectiveness.

Principle 6: The MHMRSAS system should redirect and reinvest resources as necessary to address consumer need.

To assure adequate capacity at all levels of service intensity, resources must be administered flexibly so as to enable the redirection of funding among various services as demanded by consumer and community need. The single stream of funding, administered by a single local organization with the authority to redirect resources as needed, enables the most appropriate deployment of public funds within the limits of the total allocation. By utilizing resources flexibly, it will be possible to expand the use of innovative treatment models and rehabilitative services. Reinvestment of resources that can be made available through increased efficiency, cost effectiveness, and diversion from costly inpatient care,

will provide the ability to address many service shortages around the state that have traditionally caused waiting periods for service.

Principle 7: A network of public and private providers with sufficient expertise and capacity is essential.

To ensure that consumers and their families have access to specialized clinical, social, and habilitation/rehabilitation services, care should be taken to preserve essential elements of the current local, publicly funded MHMRSAS system.

For decades, this system has functioned as the de facto adverse risk pool for the private sector. While not able to serve everyone in need, the present array of publicly funded services provided by both public and private providers, has served a particularly vulnerable group of citizens who otherwise would be unserved or who would place additional demands on local and state government.

Local communities must be assured of the availability of emergency, outpatient, residential, vocational, other community-based services, acute inpatient, and long term care for citizens in need.

Principle 8: The publicly-funded MHMRSAS system should be outcome oriented.

The MHMRSAS system should focus on achieving desired outcome. Outcome should be measured in ways that are agreed to by the members of the partnership of consumers, families and providers and that are consumer centered.

Principle 9: The system should contain cost.

The MHMRSAS system should assure that costs are contained. By assuring that appropriate services are provided, more expensive and intrusive levels of care will be reduced through the utilization of the broad array of community-based services. This is best accomplished by placing both the resources and the responsibility with a single local organization. The system should permit flexibility in managing cost as long as outcomes are achieved.

Principle 10: Cost of services should not be shifted to local government.

As the MHMRSAS system is changed, costs should not be shifted to local government or other community organizations. Since the inception of community-based services, the responsibility for funding has been that of the state/local partnership. This responsibility should continue to be shared. Cost shifting will be minimized through adoption of a system based on a single integrated funding stream, planning and decision-making fixed at the local level, resources directed to the community, and use of the other guiding principles contained in this document.

"OPERATIONAL CONCEPTS"
For Virginia's Publicly-Funded Mental Health, Mental Retardation and Substance Abuse Services System

The current strengths of the Virginia system of publicly-funded MHMRSA services stem from the fact that the majority of the services are planned, coordinated, and administered in the local community where the recipients of service reside as intended by Chapter 10, Title 37 of the Virginia State Code.

A locally appointed board of concerned citizens who know the community is responsible for the system of care. The result is maximum integration of the mental health services in the community, greatest opportunity for coordination with other community human service agencies, and community ownership which has resulted in the annual investment of over $100 million of local government funding as well as significant public and private capital investment in the community MHMRSAS system. The most recent evidence of the effectiveness of the existing community-based system is the fact that the census of Virginia's state hospitals has decreased dramatically. (See attachment "C".) At the same time, there has been a marked increase in the population of Virginia. This type of achievement is unquestionable confirmation of the recommendations made repeatedly by the Hirst Commission, the Bagley Commission, the Emick Commission and three JLARC studies that the Commonwealth of Virginia should achieve a community-based MHMRSAS system.

The most significant barrier to a fully-integrated system of services and to a cost-effective service system is the historical separation of funding for state-operated, facility services and all other publicly-funded MHMRSA services in the community. This is the system's greatest weakness. (See attachment "D".)

The Commonwealth of Virginia must build on the strengths and successes of the publicly-funded MHMRSA service system and must eliminate barriers to full integration of services. To accomplish this, the following operational concepts should be implemented:

Concept 1: ***Community Services Boards should remain the single local organization responsible for the publicly-funded MHMRSA system.***

The responsibility for planning, decision-making, and providing services should remain with the single local organization designated by the Code of Virginia, the Community Services Boards (CSBs).

Concept 2: All public funds that support the MHMRSA system should be integrated at the local level through the CSB.

All MHMRSA state funds, federal funds, Medicaid funds, and those local funds required by the Code of Virginia, that are now budgeted to the State facilities and community programs, should be integrated into a single flexible funding stream managed by the Community Services Boards (CSBs). Remaining local dollars should address local priorities.

Concept 3: Public MHMRSA funding should be allocated based on eligible populations.

The MHMRSA system should have a funding mechanism based upon eligible clients enrolled. The mechanism should be implemented during a 3-5 year period to allow for adjustments among localities that will minimize disruptions in the services system. There should be careful analysis of both case rate and capitation as promising models for future funding. As populations of eligible persons increase, the Commonwealth of Virginia should provide proportionate increases in funding.

Concept 4: Eligible populations should be defined.

The State, in partnership with consumers, families, CSBs and other providers, could limit access to state-funded services through eligibility definitions. State eligibility criteria should apply only to state-funded services, including Medicaid services.

Concept 5: CSBs should provide services through a network of CSB and private providers, including the purchase of services from state facilities.

The CSBs should arrange for the delivery of services through a network of CSB and private providers, including state facilities and local hospitals. (See attachment "E".) Over a 3-5 year period, there should be an orderly transfer of facility resources to the CSBs. The transition plan should include consideration of employment of state personnel. The State Department of MHMRSAS may directly operate the facilities during this transition and assure that the capital improvement needs of the facilities are addressed.

Concept 6: MHMRSA services should be evaluated based on agreed-upon outcomes.

The CSBs should be responsible for achieving a set of outcome measures, defined by stakeholders and applied on a state-wide basis. The stakeholders include consumers, family members, local government, CSBs, public and private community providers, and state agencies. Such outcomes should include measures regarding access, consumer satisfaction, grievance procedures, utilization rates, and performance standards.

Administrative requirements should be consistent with an outcome-driven system. To achieve this, mandated procedures that expand paperwork, increase requirements that do not work to directly enhance quality of care should be eliminated. Administrative flexibility and creativity in service planning and provision should be encouraged as long as the local board is able to meet the desired outcomes.

Concept 7: Standards regarding access to services should be established.

With the assistance of consumers, families, and providers, the State should adopt access standards that enable an effective system for evaluating the extent to which services are accessible. These standards should address geographic accessibility, timeliness of access to all services, and capacity. Special attention should be given to the availability of culturally and linguistically-appropriate services.

Concept 8: The CSBs should accept responsibility and risk for services to eligible populations.

With a single funding stream and the integration of services as proposed in this document, the CSBs in Virginia should accept responsibility and risk for services to eligible opulations. As the transfer takes place, CSBs should explore joint and mutual risk-sharing arrangements.

Concept 9: The development of public/private partnerships should be continued.

A broad array of services should be provided in a cost-effective and efficient manner through utilization of public and private partnerships. These partnerships should continue to enhance service delivery, administrative support and encourage the use of technologies, among them managed care technology, to continue improving the quality and efficiency of the system. (See attachment "F".)

Concept 10: The State should retain the responsibility for persons found not guilty by reason of insanity or incompetent to stand trial.

The State Department retains responsibility for forensic in-patient care of those adjudicated "Not Guilty by Reason of Insanity" (NGRI) or incompetent to stand trial. Those persons with NGRI status, when released to the community, should receive services through the CSBs with specific funding provided by the State.

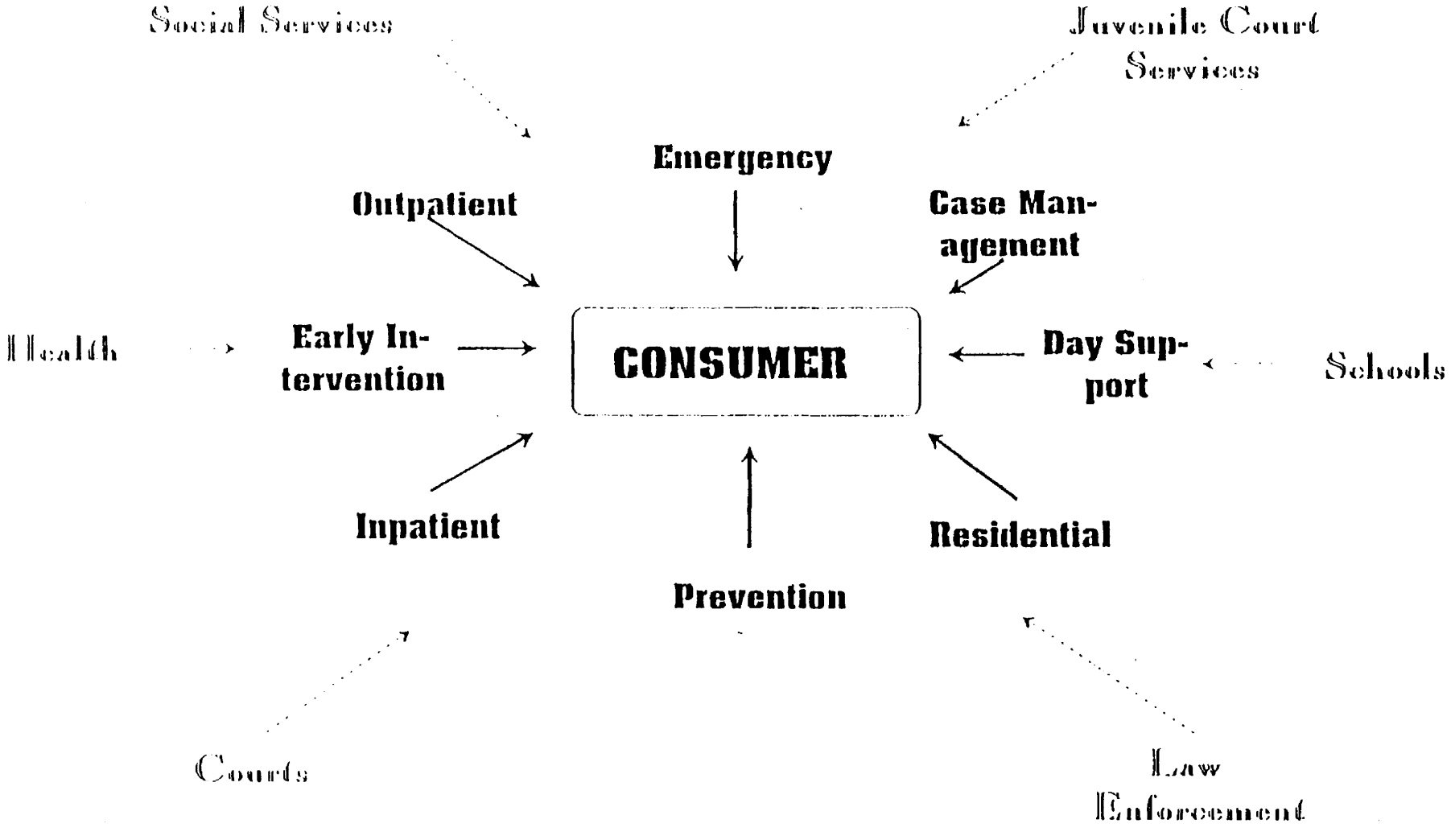
Concept 11: The MHMRSAS system should maximize Medicaid for persons with mental disabilities.

The Medicaid reimbursement system offers an opportunity to increase funding for services for consumers with mental disabilities with the federal contribution. This can be accomplished by expanding covered benefits to existing services financed by state and local funds, by broadening eligibility based on income. and by seeking additional waivers. This concept will have to be assessed in light of pending policy decisions at the federal level. It will be important to assure that any expansion of services utilizing Medicaid does not result in a significant decrease in services for low income persons who are not eligible for Medicaid.

Concept 12: The MHMRSA system changes should be evaluated to determine effectiveness.

As changes are made in various aspects of Virginia's publicly-funded MHMRSAS system, evaluation should be conducted to determine the effectiveness of the change. This evaluation should be based on specific criteria identified well in advance of implementation. Once implementation of the changes has occurred, adequate time should be allowed to realistically assess effectiveness. Based on the results of the evaluation. modifications should be proposed and implemented to resolve problems which may be identified. The evaluation process should include consumers, family members, the CSBs, and the State Department of MHMRSAS. An independent source should be responsible for this evaluation process.

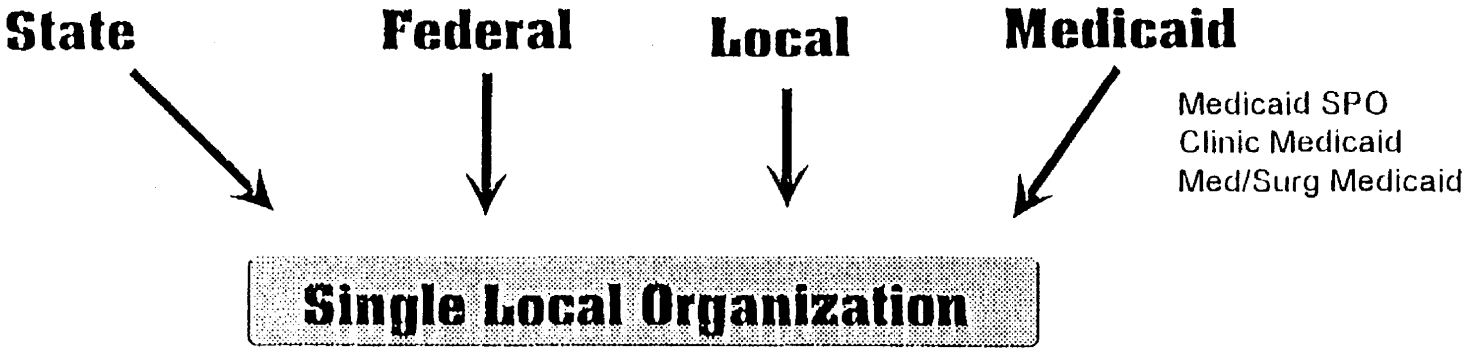
PRINCIPLE 3: MH/MR/SA SERVICES INTEGRATED AND COORDINATED



Attachment "A"

PRINCIPLE 5: PUBLIC FUNDING FULLY INTEGRATED

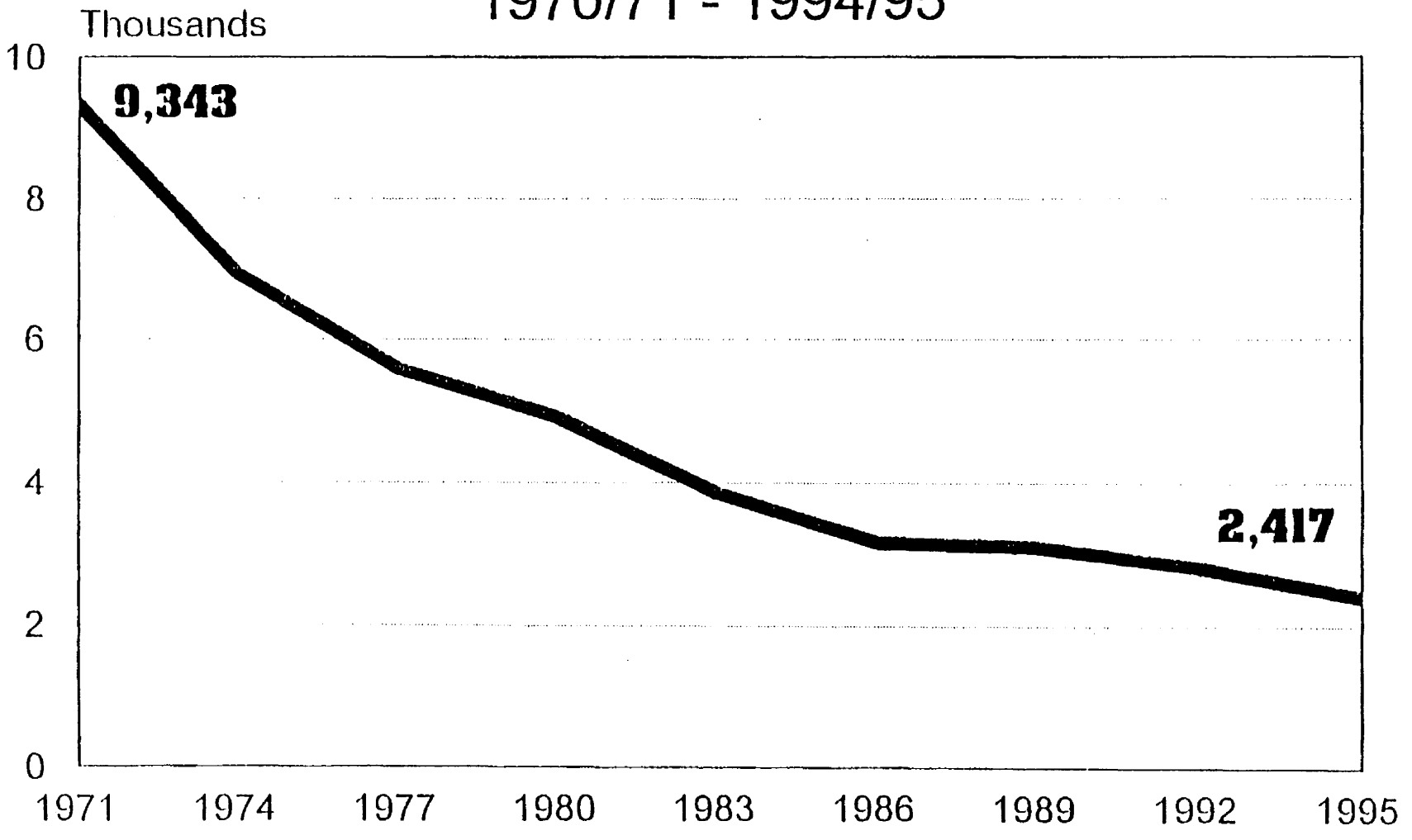
PROPOSED PUBLICLY FUNDED MHMRSA SERVICES



Attachment "B"

DECLINE OF STATE MENTAL HEALTH FACILITY CENSUS

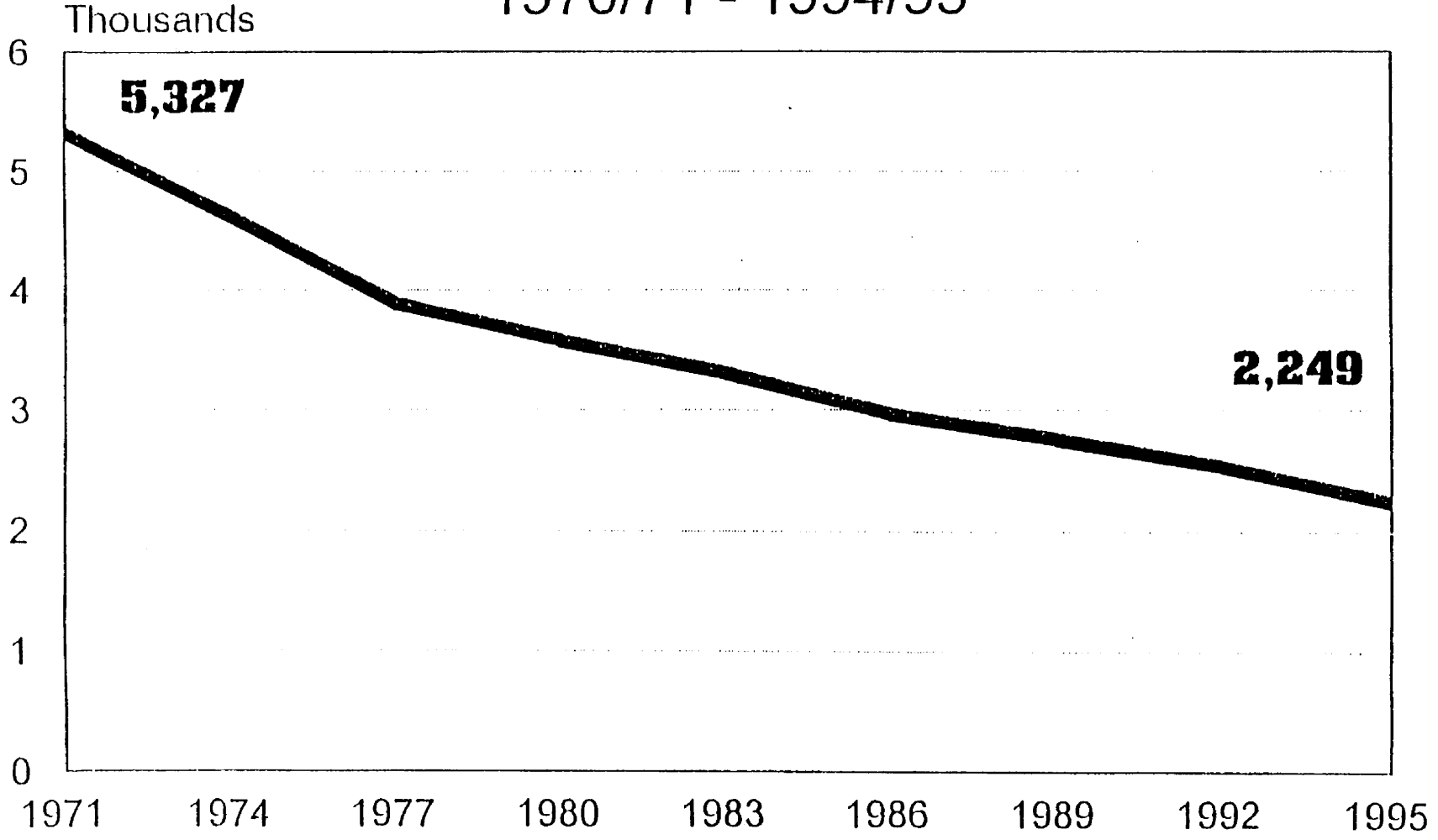
1970/71 - 1994/95



Attachment "C" - 1.

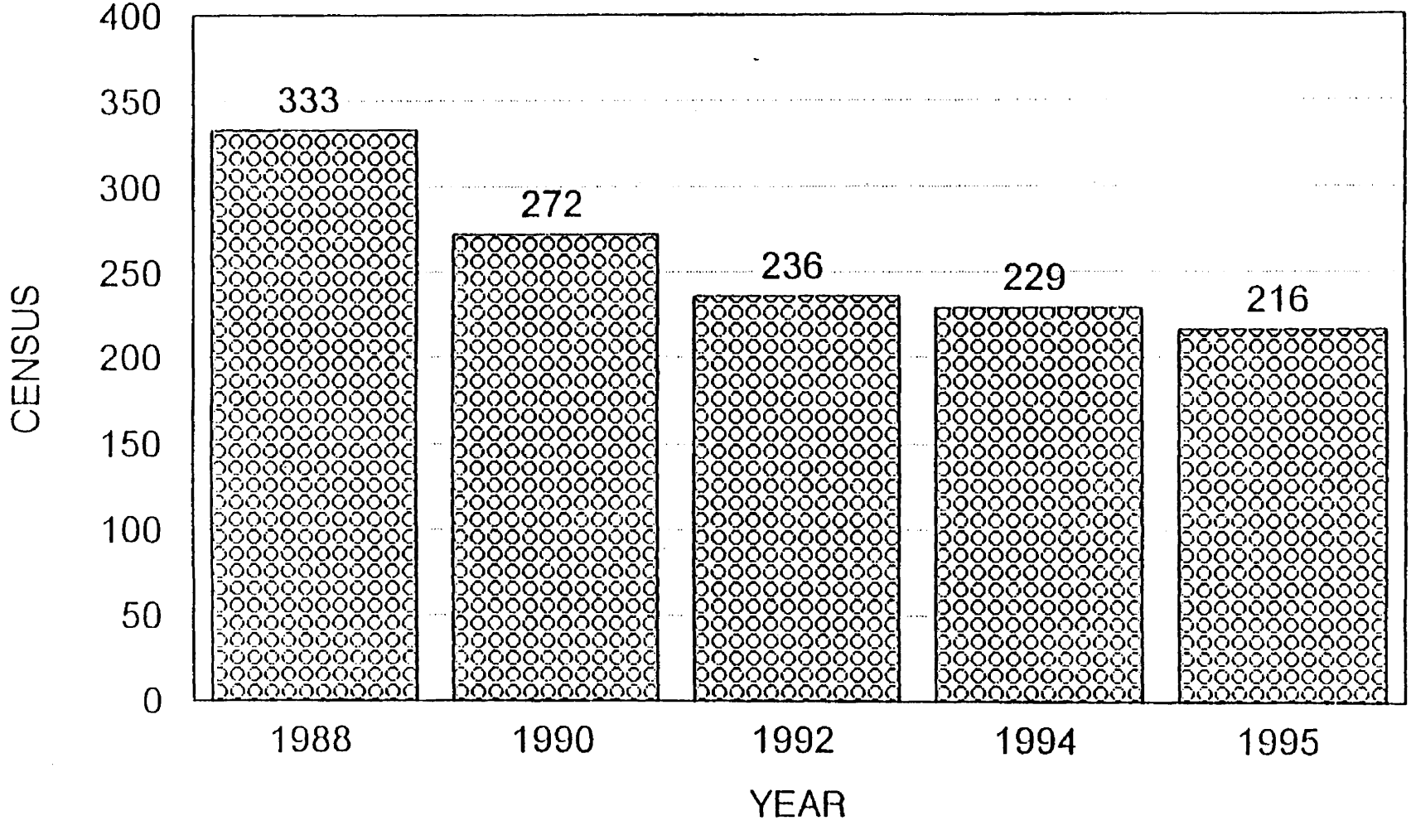
DECLINE OF STATE MENTAL RETARDATION FACILITY CENSUS

1970/71 - 1994/95



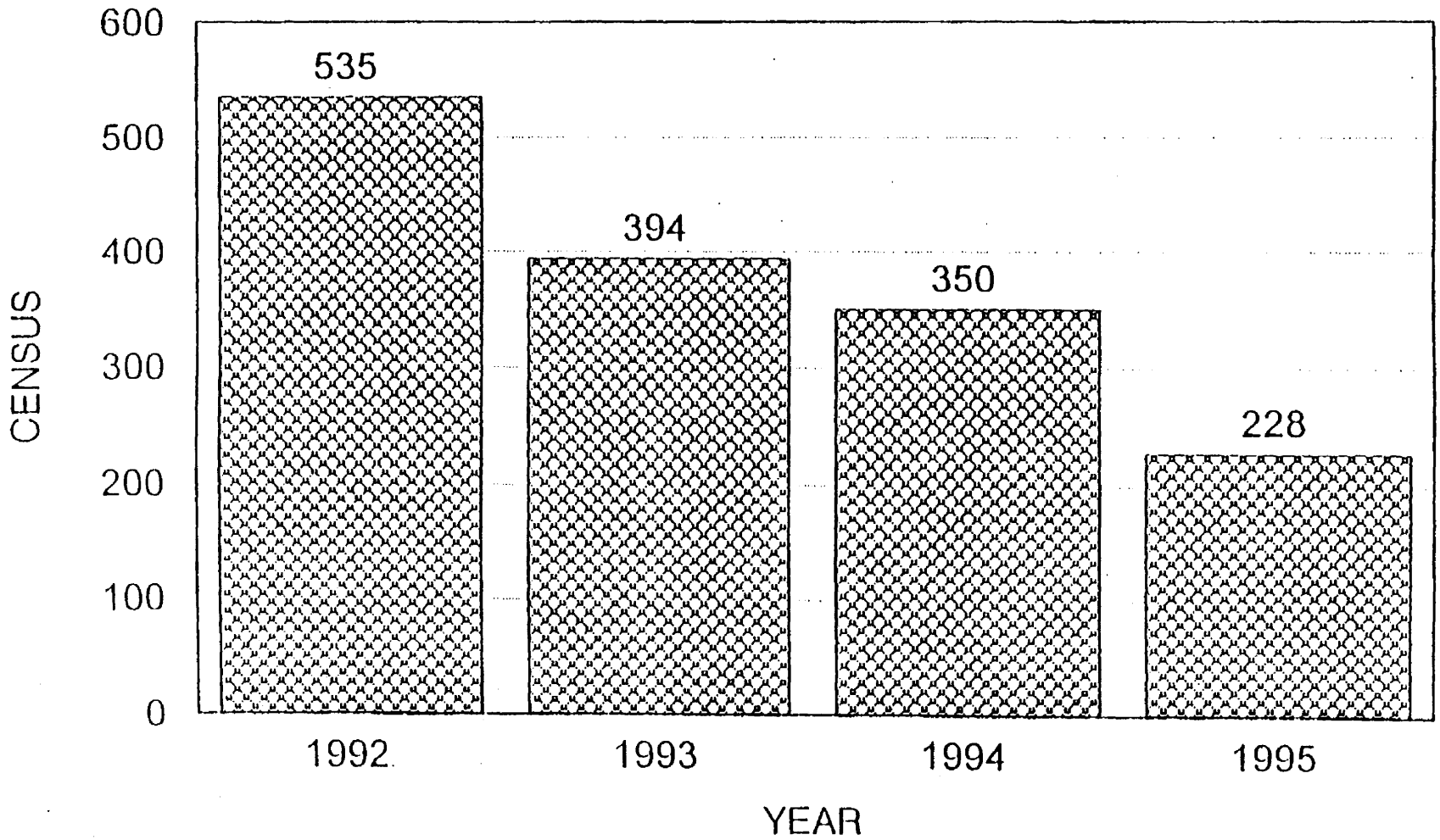
Attachment "C" - 2

HPR IV STATE HOSPITAL
ADULT AVERAGE DAILY CENSUS



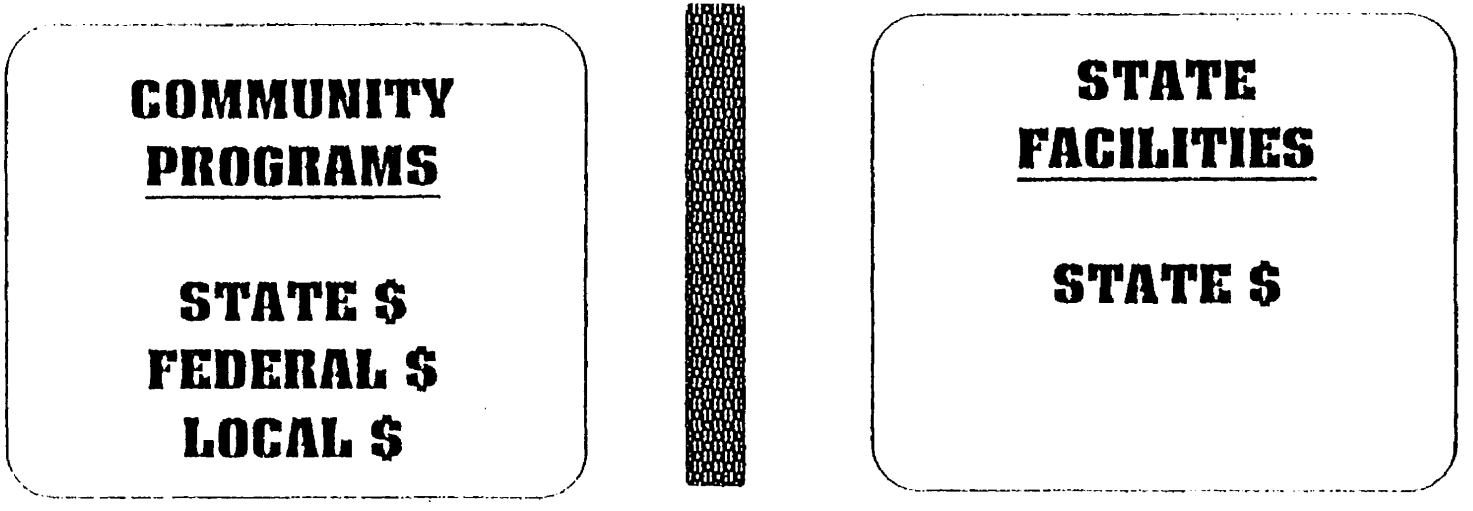
Attachment "C" - 3

HPR V STATE HOSPITAL
ADULT AVERAGE DAILY CENSUS



VIRGINIA'S GREATEST MH/MR/SA SYSTEM WEAKNESS

SEPARATION AND ISOLATION OF FUNDING



Attachment "D" - 1

DEPLOYMENT OF FUNDS

VIRGINIA DEPARTMENT OF MH/MR/SAS

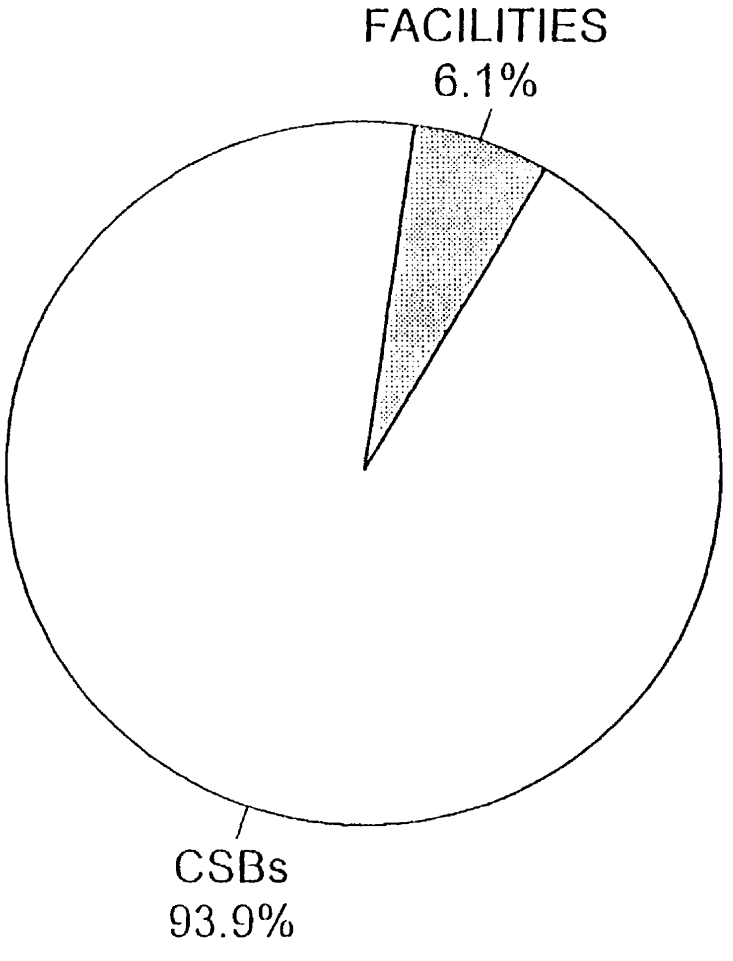
FY 1994/95

(in millions)

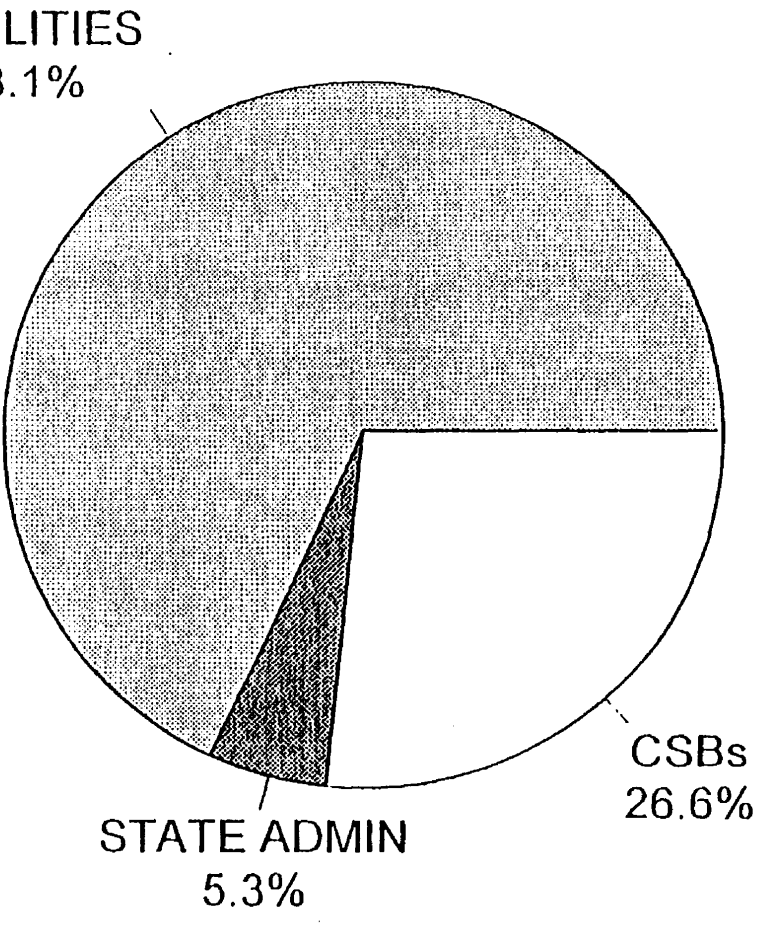
Facilities	385.7	68.1%
Communities	150.6	26.6%
Central Office	30.2	5.3%

Attachment "D" - 2

FACILITY/COMMUNITY CLIENTS SERVED AND FUNDING



CLIENTS SERVED



FUNDING